

Documenting Disability

Simple Strategies for Medical Providers

by

James J. O'Connell, MD

Barry D. Zevin, MD

Paul D. Quick, MD

Sarah F. Anderson, JD

Yvonne M. Perret, MA, MSW, LCSW-C

Mark Dalton

Patricia A. Post, MPA, Editor

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HCH Clinicians' Network • National Health Care for the Homeless Council, Inc.

P.O. Box 60427 • Nashville, TN 37206-0427

voice: 615/226-2292 • fax: 615/226-1656

E-mail: network@nhhc.org • Web site: <http://www.nhhc.org>

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PREFACE

This manual is a guide to documenting medical impairments in support of applications for the Social Security Administration's (SSA) disability benefits programs, Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). It is primarily intended for health care providers in the United States serving individuals with disabilities who are homeless or marginally housed.

The original version of this manual, *Determining Disability: Simple Strategies for Clinicians* by James J. O'Connell, MD, was published in 1997 by the Health Care for the Homeless (HCH) Clinicians' Network, National Health Care for the Homeless Council and updated in 2004 (*Documenting Disability: Simple Strategies for Medical Providers*).

This revision further updates the prior publications, based on the June, 2006 edition of Social Security's *Medical Listing of Impairments*, the latest changes for which are found at www.ssa.gov. In addition, it includes more detailed information about the appropriate documentation of impairments that co-occur with substance use disorders, originally published in June 2007 as a supplement to the 2004 manual: *Documenting Disability for Persons with Substance Use Disorders & Co-occurring Impairments*. We hope that readers will find the combination of these two manuals in one publication helpful. An extensive bibliography lists resources where more detailed information can be found about federal disability policy and disabilities frequently seen in homeless populations.

The purpose of this manual is to inform clinicians about SSA's disability criteria and to explain how they can expedite the disability determination process. The authors contend that health care providers should play an active role in routinely documenting their patients' medical impairments. By understanding the process of applying for SSA disability benefits and the requirements for providing evidence in support of a disability claim, providers can do so more efficiently and effectively. They can also use the process of disability evaluation and advocacy to engage individuals who are homeless in primary care and mental health/substance abuse services.

Two basic strategies are recommended to support applications for disability assistance:

- 1) Refer explicitly to medical criteria for disability specified in the SSA's Listing of Impairments.
- 2) For patients whose impairments do not meet or equal the level of severity specified in a medical Listing, document activities the patient can and cannot do. This strategy is most effectively accomplished in collaboration with a multidisciplinary clinical team that includes a social worker and/or vocational counselor.

We hope this document will promote stronger therapeutic relationships between health care providers and homeless people. Most importantly, we hope that its use will enable persons with disabilities to obtain the financial supports they need to achieve stability and improve quality of life.

AUTHORS

James J. O’Connell, MD, Founder and President of the Boston Health Care for the Homeless program, has worked in Health Care for the Homeless for over 20 years. A clinical instructor in Medicine at Harvard University, he works with multi-disciplinary clinical teams based in homeless clinics at Boston Medical Center and Massachusetts General Hospital, rides an outreach van run by the city’s largest homeless shelter, and provides ambulatory care at McInnis House, a short-term recuperative care facility which he helped to create in 1993. Dr. O’Connell developed the original version of this guide to documenting disabilities for homeless SSI/SSDI claimants, *Determining Disability: Simple Strategies for Clinicians*, which was published by the HCH Clinicians’ Network in 1997.

Barry D. Zevin, MD, is a physician at the San Francisco Department of Public Health’s Tom Waddell Health Center/Homeless Programs, where he served as Medical Director for many years. Board-certified in Internal Medicine and certified in Addiction Medicine by the American Society of Addiction Medicine, Dr. Zevin has led the HIV and Substance Abuse clinical teams at Tom Waddell and is also an Assistant Clinical Professor at the University of California, San Francisco School of Medicine. This document reflects his wisdom and long experience in caring for persons with disabilities who are homeless and his commitment to the active involvement of medical providers in documenting their patients’ impairments.

Paul D. Quick, MD, is a primary care physician at Tom Waddell Health Center in San Francisco. He and other members of the Health Center’s Disability Evaluation and Assistance Program worked with the San Francisco Bar Association’s Homeless Advocacy Project (HAP) to develop a curriculum for medical providers on the appropriate documentation of functional impairments in support of disability claims. Drs. O’Connell, Zevin, and Quick have served as physician trainers in the National Health Care for the Homeless Council’s Documenting Disability Trainings for Medical Providers, held nationwide since 2005.

Sarah F. Anderson, JD, is Managing Attorney of the Greater Boston Legal Services’ Health and Disability Unit and a member of the Homeless Subcommittee of the Massachusetts Disability Determination Services Advisory Committee, which investigates barriers encountered by homeless claimants in applying for SSI/SSDI benefits. She played a central role in the development and revision of both the 2004 Documenting Disability manual and the June 2007 supplement on Substance Use Disorders & Co-occurring Impairments.

Yvonne M. Perret, MA, MSW, LCSW-C, Executive Director of the Advocacy and Training Center in Cumberland, Maryland, contributed information especially on substance use disorders and co-occurring impairments. A consultant and trainer for the Federal SSI/SSDI Outreach, Access & Recovery (SOAR) initiative, she also co-authored *Stepping Stones to Recovery: A Case Manager’s Manual for Assisting Adults Who Are Homeless with Social Security Disability and Supplemental Security Income Applications* (2005).

Documenting Disability: Simple Strategies for Medical Providers

Mark Dalton, Administrator of the Belltown Community Service Office, Washington State Department of Social and Health Services, facilitates SSI/SSDI applications and enrollment in the state General Assistance program. He provided information about the history of Social Security Drug Addiction & Alcoholism policies and barriers to disability assistance encountered by individuals with chemical dependency and co-occurring mental illness.

Editor: Patricia A. Post, MPA, Policy Analyst and Communications Manager for the National Health Care for the Homeless Council, has worked with the National Council's Medicaid Reform Committee and SSI Task Force to improve homeless people's access to mainstream services, including SSI/SSDI and Medicaid.

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The Medicaid Reform Committee, chaired by the late Susan L. Neibacher, MS, Executive Director of Care for the Homeless, New York City, oversaw the development of *Documenting Disability: Simple Strategies for Medical Providers* (2004). Susan was a tireless advocate for meeting the health care needs of her homeless neighbors. Her wisdom and guidance will be sorely missed, and this publication is dedicated to her memory. Committee members and others who reviewed drafts prior to publication were:

- Douglas Berman, Policy Analyst, Care for the Homeless, New York City;
- David Buchanan, MD, John Stroger Hospital of Cook County, Chicago, Illinois;
- Vincent Keane, MDiv, Chief Executive Officer, Unity Health Care, Inc., Washington, D.C.;
- Robert Taube, PhD, MPH, Executive Director, Boston HCH Program, Boston, Massachusetts;
- Dave Ettinger, JD, Legal Aid Society of Middle Tennessee;
- Peter H.D. McKee, JD, Douglas, Drachler & McKee, LLP, Seattle, Washington;
- Michael McGeary, Executive Director, Institute of Medicine; and
- Jane Deweib, Policy Analyst for the Social Security Administration's Office of Disability Programs.

The SSI Task Force has overseen subsequent revisions and additions to the original Documenting Disability manual under the skillful leadership of Robert Taube. Members actively involved in developing the June 2007 supplement, *Documenting Disability for Persons with Substance Use Disorders & Co-occurring Impairments*, as well as this latest revision of the Documenting Disability manual were:

- Sarah Anderson, JD, Managing Attorney, Health and Disability Unit, Greater Boston Legal Services;
- Yvonne Perret, MA, MSW, LCSW-C, Executive Director, Advocacy and Training Center, Cumberland, Maryland, and trainer for the SSI/SSDI Outreach, Access & Recovery (SOAR) project;
- Mark Dalton, Administrator, Belltown Community Service Office, Washington State Department of Social and Health Services;
- Deborah Dennis, MA, SOAR project director and Vice President for Technical Assistance, Policy Research Associates, Inc., Delmar, New York;
- Dan F. Reardon, JD, Benefit Acquisition and Retention Team Coordinator, Colorado Coalition for the Homeless, Denver, Colorado;
- Laurel Weir, Policy Director, National Law Center on Homelessness & Poverty, Washington, DC;
- Jennifer Alfredson, MSW, APSW, Mental Health Supervisor of Case Management, Health Care for the Homeless of Milwaukee, Inc., Milwaukee, Wisconsin; and
- Susan Eldon, BSW, Case Manager Coordinator, Gennesaret Health Recovery Program, Indianapolis, Indiana.

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EXECUTIVE SUMMARY

This manual was written to inform clinicians about appropriate documentation of medical impairments in support of their patients' applications for Federal disability benefits. It describes efficient and effective approaches to documenting disability used by primary care providers serving financially poor and homeless adults.

This manual includes:

- A brief introduction to the major Federal disability programs, SSI and SSDI.
- A description of the sequential evaluation process utilized by the Social Security Administration (SSA) and its agents to determine eligibility for SSI and SSDI
- A brief description of the Adult Listing of Impairments used by SSA, how to use them, and where to find this information online
- Guidance in documenting Residual Functional Capacity for patients with disabilities that do not meet criteria specified in the Listing of Impairments
- Guidance in documenting impairments that co-occur with substance use disorders
- Guidelines for writing effective letters supporting disability claims and examples of successful letters
- References to other information for clinicians regarding appropriate documentation of disabilities

This manual does not address:

- Disability determination for children,
- Comprehensive information about mental health problems that independently qualify many people as disabled, or
- Numerous legal and technical questions regarding eligibility for SSI and SSDI.

Readers are referred to resources where information about these topics can be obtained.

Eligibility for SSI and SSDI is determined by the Social Security Administration. SSA contracts with a government agency in each State to make the disability determination, while SSA reviews SSI/SSDI applications to see whether they meet non-disability criteria (e.g., related to income/resources and citizenship or legal residence in the United States). Applicants must meet non-disability criteria before their claim is reviewed to determine whether or not disability criteria are met. In evaluating initial disability claims, these State disability determination services (DDSs) use a 5-step evaluation process that requires answers to the following questions:

1. Is the applicant engaged in substantial gainful activity?
2. Does the applicant have a severe impairment?
3. Does the applicant suffer from an impairment which meets or equals the severity of a listing?
4. Can the applicant do any of his/her past relevant work?
5. Can the applicant do other work that exists in the national economy, given his/her residual functional capacity, age, education, and work experience?

Key terms upon which the evaluation hinges are defined in the manual.

Diagnostic information supplied by medical providers is considered at Steps 2, 3, 4, and 5 of the sequential evaluation process. In most cases, applicants for SSI or SSDI and clinicians supporting their disability claims should be working with a social worker or vocational counselor to assure that additional required information is provided and that the application is properly prepared.

At Step 3 of the sequential evaluation process, objective data documenting certain medical conditions can automatically qualify a patient for disability benefits, eliminating the need for Step 4 or Step 5 judgments. The criteria for establishing these conditions are precisely defined in SSA's *Listing of Impairments*. This manual encourages clinicians to utilize the Listing of Impairments whenever possible, to expedite disability determinations for patients who meet one or more of these criteria.

At Step 4 of the sequential evaluation process, DDS staff are asked to determine the applicant's residual functional capacity (work-related activities that s/he can still perform despite functional limitations). Clinicians can provide a realistic basis for this assessment of their patients' functional capacity by specifying what the patients can and cannot do.

At Step 5 of the sequential evaluation process, SSA considers diagnostic information related to residual functional capacity and then determines whether a person can do other work.

Providing this information can be unnecessarily time-consuming and difficult if it is not already well documented in clinic notes or the medical record. For that reason, the authors of this manual encourage a multidisciplinary team approach to documenting disability as a routine part of clinical practice, with the medical provider as a central part of that team. This is especially important for individuals with disabling medical conditions that do not clearly meet criteria specified in (or equivalent to) the Listing of Impairments.

Clinicians who understand the sequential evaluation process, who use the Listing of Impairments, and who appropriately document medical impairments and their effects on functional capacity, observed over time, can quickly and accurately provide the medical documentation necessary to support disability claims.

INTRODUCTION

The Importance of Disability Assistance

The most important sources of assistance for Americans with disabilities are two Federal programs administered by the Social Security Administration (SSA) – Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). SSI and SSDI constitute a safety net for persons with disabilities, providing both cash assistance (monthly checks) and eligibility for health insurance (Medicaid and/or Medicare).

There is increasing awareness of the role of disability in precipitating and prolonging homelessness. People living without homes suffer extraordinary and well-documented health risks associated with poverty, overcrowding, and poor access to health care. Any national strategy to end and prevent homelessness must include adequate financial supports that allow persons with disabilities to secure housing and meet other basic needs, including health care.

Disability precipitates and prolongs homelessness. Research suggests that physical and cognitive impairments are among the factors that increase the likelihood of becoming and remaining homeless if services to meet basic needs are not provided (CN 2002, CN March 2003). Homelessness itself can be an indicator of functional impairment and often a marker of disability. Indeed, people with disabilities constitute the “chronically homeless” population in America.¹

People who are homeless suffer disproportionately from mental impairments. Roughly half of all people with serious mental disorders have co-occurring substance use disorders and half of people with substance use disorders have co-existing mental illness, regardless of their housing status (NAMI, 2006). The prevalence of these disorders is considerably higher among people who are homeless (Bonin et al. 2004). According to conservative estimates, about 30 percent of homeless people have serious and persistent mental disorders, compared to about 3 percent of all adults (CN Oct 2006). Substance use disorders are also overrepresented among people without stable housing, who are estimated to be 2–5 times more likely to have these disorders than the general population (CN Oct 2006). Approximately two out of three homeless people in the United States (66 percent) have an alcohol or drug problem (Burt et al. 1999).

Disability assistance can mitigate health risks associated with homelessness. The most important sources of assistance for Americans with disabilities are two Federal programs – Supplemental Security

¹ According to the Federal definition, a chronically homeless person is defined as “an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least four (4) episodes of homelessness in the past three (3) years.” A disabling condition is defined as “a diagnosable substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions.” (Collaborative Initiative to Help End Chronic Homelessness, 2002 notice of funding announcement. www.hud.gov/offices/cpd/homeless/apply/2002nofa/section3faq.pdf). [accessed 8/7/07]

Income (SSI) and Social Security Disability Insurance (SSDI) – which provide cash assistance and eligibility for public health insurance (Medicaid/Medicare). Those who qualify for SSI/SSDI are also more likely than others to obtain available low-cost housing, including supportive housing (Dennis et al. 2007, Burt and Sharkey 2002, p. 38). By increasing access to healthcare and housing, these programs can mitigate the extraordinary health risks associated with homelessness, expedite recovery, improve quality of life, and help a number of beneficiaries achieve stability and participate in gainful employment (Dennis et al. 2007). Expediting SSI/SSDI benefits is therefore extremely important to protect and increase economic security as well as to prevent and resolve homelessness.

Many homeless people considered likely to qualify for SSI/SSDI do not receive benefits.

Unfortunately, only a small proportion of the homeless population in America receives Federal disability assistance. In a national study of homeless assistance providers and their clients conducted in 1996, only 11 percent of homeless service users received SSI and 8 percent had qualified for SSDI (Burt et al. 1999). Local studies conducted since then suggest that homeless disability claimants are denied benefits at significantly higher rates than other claimants, often for failure to negotiate the arduous application process, rather than for lack of severe medical impairments that meet SSA disability criteria.²

Case managers working in Health Care for the Homeless programs have reported that as many as 80 percent of their uninsured clients should have qualified for SSI or other disability assistance but had not done so (Post 2001, 72–73). People experiencing homelessness often fail to qualify for Federal disability assistance due to a variety of system barriers – lack of access to health services, insufficient documentation of functional impairment, remote application offices, complex application processes, lack of transportation— despite the high likelihood that they would meet eligibility requirements. These obstacles are exacerbated by mental impairments and the lack of stability necessary to see a complex application process through to completion.

Facilitating applications for disability benefits is perhaps the single most important intervention that clinicians can offer to minimize the health risks associated with poverty and to assure a better quality of life for many homeless people. Helping a previously uninsured patient obtain health insurance coverage also benefits the health care provider.

² A review of disability claims submitted to the Disability Determination Services in Boston, 2002 – 2006, revealed that SSI/SSDI denials were 2.3 times more common than approvals for homeless individuals, while denials for housed claimants were only 1.5 times more common than approvals (Sarah Anderson, JD, Greater Boston Legal Services; Post, 2001, Appendix D, pp. xv–xvi; updated August 2007). An earlier study by the Homeless Subcommittee of the Massachusetts DDS Advisory Committee had found that over one-third of unsuccessful disability claims submitted by homeless persons (over a nine month period in 1998–99) were denied for lack of sufficient medical evidence or failure to keep appointments for a consultative examination (Post 2001, 61).

The Central Role of Medical Providers

Medical evidence of health conditions that result in severe functional impairments is required to establish eligibility for SSI or SSDI. Patients rely upon clinicians to provide this medical evidence. Unfortunately, many homeless people who should qualify for these benefits do not receive them due to insufficient medical evidence of their impairments.

Some clinicians worry that by becoming involved in the disability determination process they might compromise their responsibility to advocate for their patients. They might also have the false impression that providing medical evidence to the government subverts their primary function as health care providers. Such ethical dilemmas can be resolved through a clear understanding that the medical provider's proper role includes providing documentation of impairment, and the government agencies' role is to determine disability.

As clinicians, we understand that physical and mental impairments can prevent individuals from participating in the work force and living independently. We also understand that with appropriate health care and social supports, many disabling health conditions can be stabilized and quality of life can be improved. As medical professionals, we are obligated by the ethical principle of beneficence to “do good” and avoid harm. As health care providers, we are the best sources of evidence for the existence of medically determinable impairments and their consequences for our patients. A number of us have cared for homeless individuals in shelters and on the streets. In many cases, we are the only medical practitioners who have observed their living situations at first hand and met their health care needs over time. Thus, **helping patients with disabilities obtain financial and medical assistance is well within our purview as health care professionals.**

“SSA regulations place special emphasis on evidence from treating sources because they are likely to be the medical professionals most able to provide a detailed longitudinal picture of the claimant's impairments and may bring a unique perspective to the medical evidence that cannot be obtained from the medical findings alone or from reports of individual examinations or brief hospitalizations. Therefore, timely, accurate, and adequate medical reports from treating sources accelerate the processing of the claim because they can greatly reduce or eliminate the need for additional medical evidence to complete the claim.”

SSA, *Consultative Examination Guide*: <http://www.ssa.gov/disability/professionals/greenbook/ce-evidence.htm>

This powerful statement captures the essence of what we as clinicians should be striving to do for our homeless patients, who have much more difficulty completing SSI/SSDI applications than do stably housed persons.

Even if the importance of helping homeless patients obtain SSI/SSDI benefits is acknowledged, many clinicians dread the process of documenting disability, which they consider mysterious, onerous, time-consuming, and hopelessly complex. The era of managed care, with its demands for productivity and efficiency, has amplified their frustration. At the same time, the demand for determination and re-

determination of disabilities has significantly increased as other income supports have deteriorated; substance use disorders have been eliminated as a basis for disability; and private health insurance coverage has become even more exclusive and unaffordable. Community Health Centers, Health Care for the Homeless projects, and other safety net providers have been deluged with requests for assistance with disability claims.

Much time is spent retrieving and reviewing medical records and composing medical evaluations, often without a clear understanding of the criteria against which a disability claim will be judged. When called upon to write letters supporting applications for Federal disability assistance, many providers erroneously assume that simply confirming medical diagnoses is sufficient to document disabilities.

‘Disability’ is an administrative/legal determination made by an agency (such as SSA or an insurer), not a medical diagnosis. It is the conclusion of an administrative process conducted by a disability determination service. Statutes and regulations make it clear that SSA decides if a person is disabled, not medical providers. The role of clinicians and others is to provide documentation, or evidence of disability. In other words, medical professionals are asked to provide the facts – diagnoses and functional limitations – that are necessary to determine disability. That’s why a simple statement such as “my patient is disabled” is not sufficient.

“Only after studying the disability criteria specified in the SSA Listing of Impairments did we realize that what we had previously documented in letters supporting disability claims rarely addressed these criteria. Now that we know and understand what is necessary to document impairments associated with medical disorders, we make a point of including the salient points in our chart notes.”

— Jim O’Connell, MD, Boston Health Care for the Homeless Program

Persons seeking disability assistance for chronic conditions such as diabetes, asthma, or low back pain often know they are impaired but do not understand the application process. Clinicians can carefully review the Listing of Impairments with their patients and arrive at a mutual understanding of the likelihood that disability benefits will be approved. In that way, if more information is needed, or if more studies are required, the patient will understand the reasons. Trust and mutual respect are critical, as this process often requires the patient to reveal a detailed and painful history to fill voids in the medical record. **Documenting disability, long the bane of the busy clinician and the overwhelmed patient, can become the cornerstone of a trusting therapeutic relationship that promotes patient adherence to the plan of care.**

For these reasons, we **strongly recommend that treating physicians write letters of support for disability claims, whenever possible.** To facilitate this process, the clinical team should routinely document their patients’ medical impairments in office charts and medical records.

Documenting Disability: Simple Strategies for Medical Providers

Careful specification of medical disorders that meet SSA disability criteria and thorough documentation of functional impairments that result from disabling health conditions, observed over time, are essential elements of providing quality health care – especially for patients at highest risk of falling through the cracks in our fragmented health and social service systems.

This manual was written by medical providers experienced in the care of individuals with disabilities who are homeless. It explains exactly what is expected of clinicians who are asked to provide medical evidence supporting their patients' disability claims, and how to do so in the most efficient and effective ways.

FEDERAL DISABILITY PROGRAMS

The Social Security Administration administers two major programs for people with disabilities, Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). To qualify for benefits, applicants must meet both non-medical and medical disability criteria. The medical standards for disability are the same for both programs, while the non-medical standards are different.

Supplemental Security Income (SSI)

SSI (Title XVI of the Social Security Act) is a federally financed, needs-based program that guarantees a national income level for eligible individuals who are aged, blind or disabled and have limited income and resources.³ In most States, persons who qualify for SSI are also eligible for Medicaid.⁴

Most States provide optional supplemental payments to some or all SSI recipients, to help them meet needs not fully covered by federal SSI payments.⁵ These supplemental payments vary from State to State and reflect differences in regional costs of living. Supplementary payments may be made directly by the State or combined with the federal SSI payment, by mutual agreement of SSA and State agencies (SSA Handbook §2181). SSI payment levels are also affected by the beneficiary's living arrangement (obligation to pay for shelter). This means that homeless individuals are usually paid less than individuals who have rental liability.

³ The maximum federal SSI payment for 2007 is \$623 per month for an eligible individual (\$934 for an eligible individual with an eligible spouse). The actual SSI monthly payment is calculated by subtracting the beneficiary's monthly countable income from the maximum Federal amount for a given calendar year and by adding any supplementary payment provided by the State in which the beneficiary resides.

⁴ In 32 States and the District of Columbia, SSI eligibility results in automatic Medicaid coverage. In 7 other States (Alaska, Idaho, Kansas, Nebraska, Nevada, Oregon, and Utah), a separate application for Medicaid is required, but the same disability criteria are used as in the Federal SSI program. In these States, the State Medicaid agency makes the eligibility determination rather than the local SSA field office. In 11 States (Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma and Virginia), at least one standard for disability-based Medicaid eligibility is more restrictive than the Federal SSI standard. That is, there is a narrower definition of disability or a lower income or assets threshold, and/or more restrictive methods are used to count income or assets. These States are authorized to use standards that were already in place before SSI was implemented in 1972. In Massachusetts, disabled persons can qualify for Medicaid without applying for SSI, under a State demonstration program. (SSA Policy Site: POMS Section SI 01715.010 Medicaid and the SSI Program, 2/16/2001; Post, 2001, p. 11.)

⁵ As of 2007, only 6 States did not pay an optional supplement to any SSI beneficiaries: Arkansas, Georgia, Kansas, Mississippi, Tennessee, and West Virginia (SSA. Understanding Supplemental Security Income SSI Benefits: <http://www.socialsecurity.gov/notices/supplemental-security-income/text-benefits-ussi.htm>). Of the 45 States with optional SSI supplementation programs, some provide supplemental payments to all SSI recipients (e.g., Massachusetts and Illinois), while others limit payments to certain beneficiaries (e.g., Maryland provides supplements only to those living in a care home or assisted living facility; Washington supplements SSI payments only for recipients who are blind, or over age 65, or in foster care, or participating in the State's Developmental Disability Program, or who were grandfathered into the Federal SSI program, and explicitly excludes residents of public emergency shelters for the homeless (State Assistance Programs for SSI Recipients, January 2006 (released September 2006). http://www.ssa.gov/policy/docs/progdsc/ssi_st_asst/ [accessed 8/7/07])

Social Security Disability Insurance (SSDI)

SSDI (Title II) provides monthly cash benefits for persons with disabilities who have a recent work history. Unlike SSI, an individual's income and assets do not affect eligibility. To qualify for SSDI, an individual must meet the Social Security disability standard and must be fully insured for disability benefits – i.e., have worked in a specified number of the past 40 calendar quarters, depending on the age of the applicant. In general, SSDI beneficiaries are eligible for Medicare after they have received SSDI benefits for 24 months. They may also be eligible for Medicaid (e.g., for coverage of premiums/cost sharing, prescription drugs, or other services, depending on the State plan).

The benefit amount for SSDI is calculated based on the individual's work history. Applicants who don't have enough work credits to qualify for SSDI but meet the SSA disability standard may qualify for SSI. Persons with an extensive work history may receive substantially more money under SSDI than is available to SSI recipients. If the dollar amount of the SSDI benefit is less than the benefit available under SSI, SSDI beneficiaries may also receive an SSI supplement.

SSA Definition of Disability

To qualify for SSI or SSDI an individual must be determined disabled according to the Federal definition:

A disabled adult is defined as:

“... an individual [age 18 or older who is] unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months”

(42 U.S.C. § 1382c(a)(3)(A); 42 U.S.C. § 423(d)(1)(A))

To satisfy this definition, disability claimants must have enough **medical evidence** of a physical or mental impairment from their treating physician or from a consulting physician authorized by the agency that makes disability determinations for the Social Security Administration in each State.⁶ Sufficient medical evidence consists of “signs (objective findings by a medial provider), symptoms (subjective complaints by the claimant), and laboratory findings” to substantiate the disability claim (Morton, 2003, Chapter I).

⁶ Allowance (approval) rates for SSI/SSDI applications vary widely from State to State. In Massachusetts (which has a higher allowance rate for disability claims than most other States), a review of disability claims submitted to the DDS in Boston, July 2002 – September 2004, revealed that only 29 percent of claims from homeless people were allowed, compared to 38 percent of claims from non-homeless people; denials were 2.3 times more likely than allowances for homeless claimants, compared to 1.5 times more likely for non-homeless claimants. The Massachusetts DDS Advisory Committee appointed a Homeless Subcommittee to investigate barriers encountered by homeless claimants in applying for SSDI/SSI benefits. Data collected by that group indicate that disability determinations are often delayed when homeless claimants fail to list contact information for all medical providers, and that higher percentages of homeless than non-homeless claims are denied due to insufficient medical evidence or failure to keep appointments for consultative evaluations. (Sarah Anderson, JD, Greater Boston Legal Services; Post, 2001, Appendix D, pp. xv-xvi)

DISABILITY DETERMINATION PROCESS

Steps through the Application Process

1. **Intent to File** Individuals applying for Social Security benefits first have to notify the Social Security Administration of an intention to file. This can be done in person, by phone, or online at <http://www.socialsecurity.gov/applyforbenefits>. For SSI, the clock starts ticking at this point.
2. **Application** The next step is filing an application with SSA. If the application isn't complete within a certain time after notification of the intent to file, the case will be closed. SSA responds to verbal or written inquiries about eligibility for SSI or SSDI by giving the individual an appointment to apply. If the appointment is missed, SSA should send the individual written notice that an application must be filed to receive an initial determination. In the case of SSI, an application filed within 60 days of the notice date will be treated as if it were filed on the date of the verbal or written inquiry (20 CFR 416.340 and 416.345). In the case of SSDI, an application filed within six months of the notice date will be treated as if it were filed on the date of the written inquiry (verbal inquiries do not count) (20 CFR 404.630).
3. **Presumptive Disability (PD)** In certain cases, a claimant may be found presumptively eligible for SSI benefits which can be paid for up to six months while evidence is being gathered for a full disability determination (Rosen, 2001). This can expedite Medicaid coverage and access to needed health services. SSA Field Offices have limited authority to approve presumptive disability from a list of specified impairments, including amputation at the hip, deafness, blindness, bed confinement, severe mental retardation, and opportunistic infections associated with HIV (20 CFR §§ 416.931–416.934; POMS DI 23535.000).

DDS staff may approve PD if they believe there is a high probability that the applicant will be found disabled after additional evidence is obtained. Impairments with “high PD potential” include mental deficiency, neoplasms, diseases of the central nervous system resulting in paralysis or motor dysfunction, and chronic renal disease. But DDS may not consider the presumptive disability option in every case where they could. Advocates should recommend to DDS that PD be approved if they think it is warranted. SSI outreach demonstration projects have confirmed the effectiveness of this approach, especially for mentally impaired adults who are homeless.⁷
4. **Disability Determination** Under an agreement with SSA, State disability determination services are given the responsibility of determining whether the applicant (claimant) meets Federal standards that

⁷ SSA authorized an outreach demonstration project conducted by the University of Maryland, 1993–2002, to approve presumptive disability for homeless adults with severe and persistent mental illness. Virtually 100 percent of applications submitted presumptively received final approval from DDS (Perret, 2003). In FY 2004, SSA awarded a total of \$6.6 million to 34 community-based organizations to assist chronically homeless individuals apply for SSI and SSDI benefits. One of the optional project activities funded by these 3-year Homeless Outreach Projects and Evaluation (HOPE) grants is screening of claimants for presumptive disability. SSA policy on presumptive disability was still evolving at the time this manual was written.

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are required to qualify for disability benefits. SSA forwards the application to the DDS, which usually sends questionnaires to the patient, family, and friends named by the patient, asking for information about the patient's daily functioning. The DDS will also send a request for medical records and a statement to the treating physician and any other treating sources (see "Who Can Document a Medical Impairment?" below). If the treating source does not respond, or if the records or response are inadequate, or if no treating source can be identified, DDS may re-contact the patient's treating source(s) and ask for supplemental information or arrange for a consultative examination with a medical or osteopathic physician, psychologist or other health professional on its list of medical examiners.

- a. **Initial determination** The disability determination is made by a medical or psychological consultant and a disability examiner. The average initial allowance rate for decisions on applications for SSI/SSDI benefits in FY 2006 was **35 percent** (FY2006 DIODS Extract, Office of Disability Programs, SSA).⁸ Unfortunately, some providers ignore requests for evidence at the initial determination level because they mistakenly believe that there is no significant chance of an initial allowance. Lack of sufficient medical evidence is an important reason why applications filed by many homeless claimants are not approved at this stage. Allowance of disability claims at the initial determination should be the primary goal. It is also important to support patients in appeals of inappropriately denied disability claims.
- b. **Reconsideration** If benefits are not awarded, the claimant has 60 days to file a request for reconsideration (more if s/he can show good cause for not responding sooner). (At each stage of the adjudication process, the claimant has 60 days to submit a written request for review at the subsequent stage.) Claimants should be strongly urged to file a written request for reconsideration well before the 60-day deadline. New evidence may be presented at reconsideration, and a new analyst and physician reviewer will consider the case. On average, **13 percent** of disability claims were awarded to disability claimants at this phase in FY 2006 (Ibid.).
- c. **Hearing** If the claim is again denied, the applicant has 60 days to request a hearing before an administrative law judge (ALJ) who works for SSA. The ALJ reviews each claim anew and will accept new evidence. Health workers and social workers assist patients with their applications and benefits advocacy. If the application needs to proceed to the ALJ hearing level, the patient is often referred to a lawyer. Clinicians have consistently more credence from ALJs during appeals hearings when they can state that they have observed patients over a period of time, living in shelters, and can attest clearly to their marked loss of social functioning as a result of medical or psychiatric impairments. Too many applicants give up after one or two denials, unaware that ALJs allow **62 percent** of the initial claims they hear (Ibid.), despite the fact that each of those claims has been "carefully reviewed and regretfully denied" on two prior occasions (GAO 2004).

⁸ Allowance rates specified in this section are national averages, which vary considerably from State to State, within individual States over time, and even among ALJs. For an analysis of the variation in allowance rates by State and among ALJs, 1980–2004, see Social Security Advisory Board, 2006 (Chartbook B): <http://www.ssab.gov/documents/chartbook.pdf>

- d. **Appeals** If the case is denied at the ALJ hearing level, the next step of appeal is to the SSA **Appeals Council** in Falls Church, Virginia. At this level, claimants can also initiate a new application. But cases at this step take months to years, and most cases don't make it that far. The FY 2003 allowance rate for medical decisions by the Appeals Council was only **2 percent** (Ibid.). If the claim is still not awarded, the case may go to Federal court. At present, the Social Security appeals process is extremely time-consuming; waits of up to two years for an administrative hearing and up to two more years for action by the Appeals Council are not uncommon. Thus, providing compelling evidence of disability at the earliest stages is to everyone's advantage, especially the patient's.
- e. **Disability Service Improvement (DSI) Process:** Effective August 1, 2006, SSA implemented a new process for handling initial SSI and SSDI disability claims in SSA Region I (Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, and Connecticut). Key points include: (1) elimination of reconsideration and the Appeals Council; (2) implementation of a new federal reviewing official; (3) centralization of medical and vocation experts, and (4) a quick disability determination (QDD) for selected cases. 20 CFR Part 405. Region I advocates' experience with the DSI process has been far from positive. Expansion of DSI nationwide is up in the air as of this writing (*Social Security Forum*, vol.29, no.6, p.1, NOSSCR (June 2007)).
5. **Allowance** If SSI benefits are awarded, the application effective date (the point at which Social Security payments can begin) will usually be the first day of the month after the protective filing date (the date on which the patient notified SSA of the intention to file). SSI benefits are not retroactive beyond the protective filing date. For SSDI, it is more complicated: there is a waiting period of 5 calendar months from the time the person became disabled (*not* from the date of application) before benefits can begin. SSDI payments begin 1 month after the waiting period ends, and benefits are retroactive, covering up to 12 months before the month the application is filed.

There are two types of favorable disability determinations (allowances):

- **Medical allowances** are based upon a finding that the applicant meets or equals a listed impairment. The SSA's Listing of Impairments describes conditions so obviously inconsistent with work that benefits are awarded without considering the applicant's age, education or work experience.
- **Medical-vocational allowances** are based upon consideration of the applicant's age, education, work history, and residual functional capacity. In very simplified terms, unskilled applicants unable to perform past work are likely to receive medical-vocational allowances if they are:
 1. 50 to 54 and limited to sedentary work;
 2. 55 to 59 and limited to light work; or
 3. 60+ and limited to medium work.

The rules are somewhat more lenient for illiterate applicants.

(See Documenting Residual Capacity, below, for definitions of these work levels.)

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In FY 2004, **38.7 percent** of SSI allowances for adults were based on meeting a Listing, **4.3 percent** of allowances were based on equaling a Listing, and **26.9 percent** of allowances were based on medical-vocational considerations (SSI Annual Statistical Report, 2005).

- 6. Continuing Disability Review (CDR)** After a disability case has been awarded (approved), SSA is required to conduct a CDR at specified intervals, established at the time of approval. How often the case is reviewed depends on whether the beneficiary's condition is expected to improve. A CDR is scheduled 6–18 months after benefits start if medical improvement is expected, in 3 years if improvement is possible, or in 7 years if improvement is not expected.

Patients sometimes come to caregivers in a panic, reporting that “Social Security is cutting me off.” This usually means that the DDS has been asked to review the case (i.e., conduct a CDR) to determine if the patient is still eligible for benefits. If the patient doesn't respond to a CDR notice or doesn't go for required medical examinations, the benefit may be cut off, and the patient could even end up owing money back.

The process of developing evidence in a CDR is the same as that used in the initial review of a disability claim, with one significant difference. For benefits to be terminated, there must be evidence that the individual's condition has medically improved (decreased in severity), based on changes in the symptoms, signs and/or laboratory findings associated with conditions present at the last favorable medical review (SSDI: CFR 404.1579; SSI: 20 CFR 416.988 et seq.). Although the claimant still has the responsibility to provide medical evidence of his or her impairment(s), it is ultimately SSA's responsibility to determine from the medical evidence provided that there has been medical improvement.

Clinicians can support continued disability assistance for their patients by providing evidence that there has been no medical improvement related to ability to work since the last favorable disability determination. Continued attention to functional status in clinical care and chart notes is good medical practice and saves time if a CDR is required.

The Sequential Evaluation Process

DDS uses a 5-step sequential evaluation process to initially determine disability for adults:

Step 1: Is the applicant engaging in Substantial Gainful Activity?

Step 1 addresses whether the claimant is currently working for pay or profit and how much income s/he is receiving from that work (i.e., full-time or part-time activities, including those that are legal or illegal).

- **What is Substantial Gainful Activity?** Substantial gainful activity (SGA) is the performance of significant physical or mental tasks that are “productive” in nature – that is, resulting in income that equals or exceeds an amount set annually by SSA.⁹ Individuals earning more than that amount are considered to be engaged in substantial gainful activity and are not eligible for disability benefits, unless they can show exceptions apply (20 CFR §§ 404.1573–74, 416.973–74). SGA is intended to describe work on a full-time, reliable basis – 6–8 hours a day, 5 days a week. The fact that a claimant can do some work does mean that s/he is not disabled, however, according to SSA’s definition. In most cases, clinicians rely on caseworkers or attorneys to address this area of the disability application.

If the answer to Question 1 is YES, the claim is denied at this step. If NO, proceed to Step 2.

Step 2: Does the applicant have a severe impairment?

Step 2 attempts to screen out groundless claims by assessing evidence of the severity of the applicant’s impairment.

- **What is a Severe Impairment?** This is a threshold test used to screen out very weak claims. An impairment is considered “severe” if it interferes with an individual’s ability to perform basic work activities – such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, handling, seeing, hearing, speaking, understanding, carrying out and remembering simple instructions, using judgment, responding appropriately (to supervision, co-workers and usual work situations), and/or dealing with changes in a routine work setting. Evidence of the impairment’s severity may be provided by clinicians who have observed the applicant’s functioning or by others who have observed the applicant attempt to perform basic work activities in employment or social settings. A severe impairment is interpreted by SSA as the minimal level of impairment required for disability status. In evaluating cases at this step of the sequential evaluation process, SSA is supposed to look at the functional effects of all impairments on the whole person, rather than assessing each impairment separately. The claims of patients whose impairments are not considered severe are denied.

⁹ “Beginning January 1, 2007 a Social Security Disability beneficiary can earn \$900 a month as a result of ‘substantial gainful activity’ or SGA and remain eligible for benefits. Under the new rule, monthly SGA earnings limits will be automatically adjusted annually based on increases in the national average wage index. This amount applies to people with disabilities other than blindness. For blind persons, effective January 2007, earnings averaging over \$1,500 a month generally demonstrate SGA.” (Social Security Online, Answer ID 317: <http://ssa-custhelp.ssa.gov/>).

If the answer to Question 2 is NO, the claim is denied at this step. If YES, proceed to Step 3.

Step 3: Does the applicant suffer from an impairment which meets or equals the severity of a listed impairment?

Step 3 utilizes the **Listing of Impairments**, a published list of specific physical or mental conditions that are so severe that SSA has determined that persons suffering from these are *automatically* considered disabled without further inquiry. Step 3 is often the critical step for physicians, psychologists and other acceptable medical sources who are responsible for completing medical evaluations of individuals seeking disability assistance.

- ***What is a Listed Impairment?*** The Social Security Administration publishes a book called *Disability Evaluation under Social Security*, also known as the Blue Book. In the Blue Book, SSA lists each body system, along with criteria for different disabling medical conditions. There are two sets of listings, one for children and one for adults. (When using the Blue Book, be sure you are in the right section.) The Blue Book is available at <http://www.socialsecurity.gov/disability/professionals/bluebook/> or may be obtained in hard copy from SSA (see p. 22 for information about how to order).

If the available medical evidence shows that the claimant has an impairment that meets the level of severity described in a listed impairment and has lasted or is expected to last at least 12 months or result in death, that person will be determined to be disabled based on the medical considerations alone and should be awarded benefits. Frequently, however, claimants are denied benefits for lack of adequate medical documentation supporting all required elements of the relevant Listing(s) and/or specifying the expected duration of their impairment(s). Thus, providing clear and precise information related to every element of the relevant Listing(s) can be critical.

Although most people who qualify for benefits at Step 3 do so by meeting a Listing, a person whose impairments are substantially equivalent in severity to a Listing can also qualify.

- ***What is “Equivalent to a Listing?”*** Patients whose impairments do not meet a Listing may nonetheless meet the disability standard by having impairments that are substantially equivalent to a Listing if the medical findings are at least equal in severity and duration to the listed findings (20 CFR 404.1526). Sometimes a patient’s impairments do not by themselves meet a Listing, but taken together have the same impact on a patient’s ability to work as a listed impairment. A patient may not satisfy every element of the Listing, yet in reality may have a more limiting set of problems.

For a condition to be determined “medically equivalent” to a Listing, the unique combination of medical impairments must result in functional limitations equivalent to those reasonably expected for a person actually meeting the Listing of Impairment. That is, the patient’s impairment(s) must be “medically equal” to the listed impairment(s). SSA compares the patient’s impairment(s) to the relevant Listings and determines if a Listing is equaled.

Clinicians are not limited to describing the severity of a patient's impairments in letters supporting disability claims, expecting that SSA will check for equivalence to a Listing. Advocates recommend that clinicians offer an opinion (for SSA to evaluate) on whether the evidence shows equivalence to a particular Listing.

While the latest reported percentage of allowances based on equivalence is rather low (6.1 percent in 2002 for those 18–64, according to the 2003 SSI Annual Statistical Report), well-prepared medical records and evaluations would increase the likelihood of an allowance at step 3 (or step 4). The critical lesson for providers is that **persons who meet or equal the criteria for a listed impairment are considered disabled by SSA and the sequential process is complete.** (The Listing of Impairments is discussed in more detail under “Using the SSA Listing of Impairments,” below.)

If the answer to Question 3 is YES, stop. Disability has been established. If NO, proceed to Step 4.

Step 4: Does the applicant have the residual functional capacity to perform his or her past relevant work, i.e., work performed in the last 15 years?

For an applicant who does not have a listed impairment or an equivalent condition, Step 4 involves a review of the applicant's ability to do past relevant work by determining residual functional capacity.

- ***What is Residual Functional Capacity (RFC)?*** RFC is the most activities the individual is still able to perform despite functional limitations resulting from all of his/her impairments. Detailed information from physicians, psychologists and others who are responsible for completing medical evaluations of disability claimants is critical to assure accurate assessments.

Assessment of the RFC is particularly complicated for impairments that involve pain or fatigue, for mental impairments, and for combinations of mental and physical impairments. SSA compares the RFC with the functional requirements of the individual's relevant work performed during the past 15 years. RFC is not what a person can do occasionally; it is what a person can do “on a regular and continuing basis ... 8 hours a day, for 5 days a week, or an equivalent work schedule” (SSR 96–8p, 7/02/96: http://www.ssa.gov/OP_Home/rulings/di/01/SSR96-08-di-01.html). If DDS determines that the individual has the functional capacity to perform past work, then the disability claim is denied.

If the answer to Question 4 is YES, the claim is denied at this step. If NO, proceed to Step 5.

Step 5: Does the applicant have the residual functional capacity to perform any other work which exists in significant numbers in the national economy?

Step 5 is the final step in the sequential analysis and involves the determination of whether the claimant can perform other work.

DDS looks at work available in the regional or national economy and considers whether the RFC of the individual and other vocational factors (age, education, literacy, and work history) allow the individual to perform such work. Disability benefits will be denied if other such jobs exist in significant numbers in the national economy – i.e., in the region where the claimant lives or in several regions of the country (68 FR 51166, 8/26/03; http://www.ssa.gov/OP_Home/cfr20/416/416-0960.htm [accessed 8/8/07]).

If the answer to Question 5 is YES, disability is denied. If NO, disability is approved.

- ***What is the 12 month rule?*** To qualify as disabled, the claimant must have a severe impairment that has lasted or is expected to last for a continuous period of not less than 12 months or result in a patient's death. This 12 month ("duration") rule applies to all claims, at all steps of the sequential evaluation.

A claimant who has been impaired less than a year but is expected to be impaired for 12 months or longer may have benefits denied until it is clearer that s/he would actually meet the 12-month rule. For example, an individual who was seriously injured in car accident, hospitalized for 4 months and totally bedridden would still not qualify based on the actual duration of the impairment, unless the treating source certified that it would last more than 12 months. A forceful statement from the treating medical provider about the expected duration of the patient's impairment may be a helpful reminder to the analyst to consider this in determining disability.

In practice, the claims of patients who are expected to recover within a year are often denied at initial consideration and reconsideration. Claimants who have been impaired for nearly 12 months or slightly more but are expected to recover soon may be eligible for a closed period award or an award with a rapid medical continuing disability review.

DOCUMENTING DISABILITY

Who Can Document a Medical Impairment?

First, it is important to understand what SSA considers a medical impairment to be, who is authorized to document one for the purposes of disability determination, and what kinds of medical evidence are required to establish that an impairment exists.

- ***What is a Medically Determinable Impairment?*** SSA defines a medically determinable impairment as “an impairment that results from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques.” An impairment must be established by “medical evidence consisting of signs, symptoms, and laboratory findings – not only by the individual's statement of symptoms” (SSA Blue Book, June 2006, Part I: General Information).

Documentation of a medical impairment for the purpose of supporting a disability claim must come from “acceptable medical sources,” as defined by SSA regulations.

- ***Who is an Acceptable Medical Source?*** By acceptable medical sources, the government means medical professionals – licensed physicians, licensed or certified psychologists, licensed optometrists (for vision impairments only), licensed podiatrists (for foot and ankle impairments only), or qualified speech and language pathologists (20 CFR §§ 404.1513(a) and 416.913(a)).

The best medical evidence, according to SSA, comes from the “treating source.” By law, the statement of a treating source carries more weight than any other evidence, including the report of an outside examiner.

- ***Who is a Treating Source?*** A physician, psychologist, or other acceptable medical source that has (or did have) an “ongoing treatment relationship” with the claimant and provided medical treatment or evaluation (not just a report in support of a disability claim), is considered a treating source. The treating source may be a health care provider with a clinical doctoral degree – MD (Doctor of Medicine), DO (Doctor of Osteopathy), OD (Doctor of Optometry), or PhD (Doctor of Philosophy, e.g., a psychologist) – as long as the impairment addressed is within his or her licensed scope or practice. A doctor may report an assessment of impairment related to mental illness, even if he or she is not a psychiatrist, if it is part of the reasonable assessment the physician provides in his or her care of the patient. An optometrist can certify that a patient is blind, but would not be in a position to describe limitations related to heart disease, for example.
- ***A Nonexamining Source*** is a physician, psychologist, or other acceptable medical source who has not examined the claimant, but provides a medical or other opinion in the claimant's case.
- ***Other Medical Sources*** Medical practitioners who are not acceptable medical sources can prepare supporting letters and complete disability claims forms for their patients, but a licensed physician or

other acceptable medical source (listed above) must also provide medical evidence to establish the impairment. According to the SSA definition, “other medical sources” include nurse practitioners, physician assistants, naturopaths, chiropractors, audiologists and therapists (SSA Office of Hearings and Appeals, HALLEX Volume I, Chapter I-2-5. Obtaining Evidence.

http://www.ssa.gov/OP_Home/hallex/I-02/I-2-5.html). These “other medical sources” can also provide evidence to establish the severity of impairment and its impact on a patient’s functioning, in letters supporting initial disability claims or as consultative examiners. If nurses or mid-level providers document impairments, they should be trained to use the specific language of the Listing of Impairments and discuss each case with a doctor.

- **Non-Medical Sources** SSA may also use evidence from non-medical sources – including social service providers, educational personnel, spouses, parents and other caregivers, siblings, other relatives, friends, neighbors and clergy – to assess the severity of an impairment (or combination of impairments) and how it affects the individual’s ability to work.

Responding to Records Requests

If you receive a request from the DDS, this means that a claimant has signed a release authorizing your program/clinic to release his or her medical records to SSA. You have some options about how to respond. **The best option is to send a letter explaining your assessment of the patient’s impairment along with complete medical records.** For some conditions (e.g., AIDS, mental illness), a questionnaire may be provided. If the questions allow you to answer in a way that illustrates your patient’s impairments fully, completing the form may be sufficient. But because questionnaires are rarely as thorough as letters, experienced advocates for persons with disabilities recommend writing a letter as well, whenever possible.

If you must triage these requests, it is reasonable to send relevant records without an accompanying letter for patients known to have a weak case or whom you don’t know well. Remember that you may not be in a position to judge whether a case is weak or strong, as the patient may have sought more care elsewhere of which you are unaware. A better option is to **build an ongoing relationship with your State DDS agency that evaluates disability claims.**¹⁰ Sometimes DDS workers will tell you the specific medical evidence they need to evaluate a claim positively. In most cases, not preparing a letter will almost certainly result in a referral to outside examiners.

If the evidence provided by the claimant’s own medical sources is inadequate to determine if s/he is disabled, additional information may be sought from the treating source, or SSA may purchase a **consultative examination** (an additional examination or diagnostic test) from a qualified medical source other than the patient’s treating source. (See <http://www.ssa.gov/disability/professionals/greenbook/ce-guidelines.htm>) Outside consultative examiners often fail to comprehend the full extent of the

¹⁰ This strategy has worked well for HIV and homeless claimants in Boston. The Massachusetts Department of Disability Services’ Advisory Committee appointed a Homeless Subcommittee to investigate problems encountered by homeless claimants in applying for SSDI/SSI disability benefits and to develop strategies to resolve them. Its appointed members include DDS homeless disability claims specialists, consumers, and advocates. (Post, 2001, p.11).

individual's impairments. What's more, they are often located far from areas in which homeless people reside and may have little experience and/or skill in interacting with this population. Many patients are intimidated by unfamiliar care providers. Such patients sometimes fail to appear for a scheduled consultative examination (for lack of transportation or fear of the provider), or may show up but are too frightened or inhibited to respond candidly to the examiner's questions. As a result, individuals with significant mental illness, for whom denial of illness and paranoia are often symptoms of their impairment, often receive unfavorable reports from consultative examiners.

Therefore, we strongly recommend that treating physicians and other qualified medical providers write letters of support for disability claims whenever possible. We will discuss the specifics of how to write a letter below. In general, you will be asked to say what is wrong with the patient, discuss treatment, and tell what the patient can and can't do. Remember, your job is to describe *impairment*, not to make a judgment about disability.

Limitations of Medical Records

Medical records are notoriously unhelpful in documenting homeless patients' impairments. Most of the reasons are obvious and revolve around their poor access to healthcare (particularly diagnostic testing and specialty care), poor coordination of care (with documentation scattered over many hospitals, cities or states), and the fact that the immediacy of basic needs when surviving on the streets or in shelters renders health care a distant and often neglected priority.

A more subtle (and formidable) problem is health care professionals' lack of training in how to use the Social Security Administration's Listing of Impairments and our lack of understanding of the process and rationale for determining disability. We tend to document medical and psychiatric problems as we were trained to do during our medical education. Hence, we often do not address the particular criteria sought by SSA in making a disability determination, and SSA dismisses our medical records as unhelpful.

To remedy this situation, we offer the following recommendations:

- **Health centers and hospitals should train all medical professionals to highlight the important criteria under each relevant Listing for patients with disabling medical conditions**, in much the same way that they routinely record vital signs, screening tests, foot examinations, and A1C levels for diabetic patients.
- **To stimulate thinking about functional impairments, providers should expand the traditional educational and occupational history** (with the help of social workers and vocational counselors) to include not only what jobs were done and when, but the duration of jobs held, reasons for leaving each job, current means of support, and reasons for unemployment and/or homelessness. Educational history can include what grade was completed, whether the individual was in regular or special education classes, and level of literacy.
- **Whenever possible, document a longitudinal history of the patient's functional capacities.** The clinical team should document any work-related tasks the patient found difficult, any difficulties with activities of daily living (see page 28 for definition), and special barriers related to the patient's living situation, such as limited access to cooking facilities.

Augmenting medical records in this way will require a significant effort on the part of medical and social service providers, working collaboratively in multidisciplinary clinical teams. Doing so will improve the experience of care for provider and patient, and will improve outcomes of documenting disability as well as clinical outcomes.

Patient Confidentiality

Two Federal laws protecting patient confidentiality are relevant to this discussion: the Privacy Act of 1974 and the Privacy Regulations of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. (More information about these laws is available in the Appendix on page 70.)

Health care providers are legally permitted to disclose an individual's medical records to SSA/DDS when SSA supplies an appropriate authorization, signed by the claimant (or a personal representative approved by that individual). The signed form, which is provided by SSA with each request for information, permits disclosure of the named individual's entire medical record (not including psychotherapy notes), unless it is noted on the form that the claimant desires to have less than the full medical record disclosed.¹¹

Some medical providers have erroneously claimed that even if such an authorization has been signed, confidentiality bars them from sending, either to Social Security or to a claimant's representative, medical records from other providers contained in the patient's file. There is no such legal distinction among medical records based on their origins, however. **No matter where an earlier record came from, if it is part of the patient's current medical record, it may be released with the patient's permission and in compliance with State and Federal disclosure laws, as part of the evidence to support a disability claim.** Many times, the originating source of earlier medical records cannot be located or these records have been destroyed, and the only source of the original records is in the more recent provider's medical file. If such records are not provided to SSA – for example, to confirm the date of onset of a claimant's disability – meritorious claims may be denied.

¹¹ Letter from the Social Security Commissioner to health care providers, health information managers, and medical records administrators, March 26, 2003. For a full explanation of SSA's obligations under HIPAA and the Privacy Act, see: How SSA-827 Meets Requirements for Authorization to Disclose Information: <http://www.ssa.gov/disability/professionals/827requirements.htm>

Using the SSA Listing of Impairments

Disability Evaluation Under Social Security (“The Blue Book”) contains medical criteria that the Social Security Administration uses to determine disability (SSA, June 2006). It is intended primarily for physicians and other health care professionals. The Blue Book is available online at: <http://www.socialsecurity.gov/disability/professionals/bluebook/>¹² Using the Blue Book online rather than the printed copy alone is important, as the listings are frequently updated and changed.

The Listing of Impairments Part A (88 pages) applies to adults age 18 and over. (A prototype of the SSA webpage where the adult listings appear is found on page 25 of this manual.) Part B provides additional medical criteria for children. (Guidance on documenting disabilities in children is beyond the scope of this manual.)

The list is divided into 14 body systems, numbered from 1.00 to 14.00 (adult listings) and from 100.00 to 114.00 (child listings). For each of these major body systems, criteria are specified for disabling impairments that are considered severe enough to prevent an adult from doing substantial gainful activity. The listings are a combination of diagnostic criteria for various conditions and objective markers of severity and poor prognosis.

Most of the listed impairments are long-term or expected to result in death or of specified duration. For all others, the evidence must show that the impairment has lasted or is expected to last for a continuous period of at least 12 months.

LISTING OF IMPAIRMENTS PART A: ADULTS

- 1.00 Musculoskeletal System
- 2.00 Special Senses and Speech
- 3.00 Respiratory System
- 4.00 Cardiovascular System
- 5.00 Digestive System
- 6.00 Genito-urinary System
- 7.00 Hemic and Lymphatic System
- 8.00 Skin
- 9.00 Endocrine System and Obesity
- 10.00 Multiple Body Systems
- 11.00 Neurological
- 12.00 Mental Disorders
- 13.00 Neoplastic Diseases
- 14.00 Immune System

SSA Publication No. 64-039, 1/03
 (“The Blue Book”)

¹² You can also order a hard copy online or by mail (SSA Pub. No. 64-039 ICN 468600, January 2003). This book can be obtained free of charge from the Social Security Administration’s Office of Supply and Warehouse Management (239 Supply Building, 6301 Security Blvd, Baltimore, MD 21235) or by contacting the SSA Public Information Distribution Center (phone: 410.965.2039; fax: 410.965.2037; e-mail: oplmsm.rpt.orders@ssa.gov).

Listings in the category of “mental disorders” specify both diagnostic criteria for various types of mental health disorders and a standard taxonomy of severity (see box).

Mental Disorders Severity Requirements

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation, each of extended duration

Source: *SSA Blue Book, Adult listings*

<http://www.socialsecurity.gov/disability/professionals/bluebook/12.00-MentalDisorders-Adult.htm>

All clinicians who provide medical evaluations or reports for patients seeking disability assistance should become familiar with the categories and the specific language of the Listing of Impairments. Disability assessments become easier and more focused when providers are familiar with SSA’s language of disability, as well as with the criteria used by disability examiners.

Medical evaluations and reports should include specific Listings and numbers and address all criteria for relevant impairments. This practice will streamline disability assessments and minimize the number of denials. The Listing of Impairments is also an effective tool to share with patients seeking to understand whether they might be eligible for disability.

The most efficient approach to documenting disabilities of homeless patients (who are impoverished and typically have severely disrupted social networks) is to find a medical Listing, provide medical evidence of the impairment, and specify functional limitations that have resulted from it. If the patient meets the criteria for one or more of the Listings, the determination process is quick and unproblematic, especially if documentation has been provided by a treating source who has known the patient and observed his/her living situation over time.

The criteria in the Listing of Impairments apply to only one step of the multi-step sequential evaluation process. At that step, the presence of an impairment that meets criteria specified in the Listing of Impairments (or is of equal severity) is usually sufficient to establish that an individual who is not working is disabled.

The absence of a listing-level impairment or its equivalent does *not* mean that the individual is not disabled, however; it merely requires the adjudicator to move on to the next step(s) of the process and apply other rules in order to resolve the issue of disability. These steps (4 and 5) require more subjective judgment on the part of the adjudicator than is required at step 3.

SSA'S DESCRIPTION OF THE LISTING OF IMPAIRMENTS

Medical Considerations

§416.925 Listing of Impairments in appendix I of subpart P of part 404 of this chapter.

Purpose of the Listing of Impairments. The Listing of Impairments describes, for each of the major body systems, impairments that are considered severe enough to prevent an adult from doing any gainful activity or, for a child, that causes marked and severe functional limitations. Most of the listed impairments are permanent or expected to result in death, or a specific statement of duration is made. For all others, the evidence must show that the impairment has lasted or is expected to last for a continuous period of at least 12 months.

Part A contains medical criteria that apply to adult persons age 18 and over. The medical criteria in part A may also be applied in evaluating impairments in persons under age 18 if the disease processes have a similar effect on adults and younger persons.

How to use the Listing of Impairments. Each section of the Listing of Impairments has a general introduction containing definitions of key concepts used in that section. Certain specific medical findings, some required in establishing a diagnosis or in confirming the existence of an impairment for the purpose of this Listing, are also given in the narrative introduction. If the medical findings needed to support a diagnosis are not given in the introduction or elsewhere in the listing, the diagnosis must still be established on the basis of medically acceptable clinical and laboratory diagnostic techniques. Following the introduction in each section, the required level of severity of impairment is shown under "Category of Impairments" by one or more sets of medical findings. The medical findings consist of symptoms, signs, and laboratory findings.

Diagnoses of impairments. We will not consider your impairment to be one listed in appendix I of subpart P of part 404 of this chapter solely because it has the diagnosis of a listed impairment. It must also have the findings shown in the Listing for that impairment.

Addiction to alcohol or drugs. If you have a condition diagnosed as addiction to alcohol or drugs, this will not, by itself, be a basis for determining whether you are, or are not, disabled. As with any other medical condition, we will decide whether you are disabled based on symptoms, signs, and laboratory findings.

Symptoms as criteria of listed impairment(s). Some listed impairment(s) include symptoms usually associated with those impairment(s) as criteria. Generally, when a symptom is one of the criteria in a listed impairment, it is only necessary that the symptom be present in combination with the other criteria. It is not necessary, unless the listing specifically states otherwise, to provide information about the intensity, persistence or limiting effects of the symptom as long as all other findings required by the specific listing are present.

(20CFR404, Subpart P, Appendix I, revised as of April 1, 2003: http://www.ssa.gov/OP_Home/cfr20/416/416-0925.htm)

Social Security Online:
<http://www.socialsecurity.gov/disability/professionals/bluebook/AdultListings.htm>

[Professionals Home](#)



Medical/Professional Relations

[Childhood Listings \(Part B\)](#)

Disability Evaluation Under Social Security (Blue Book- June 2006)

[General Information](#)

Listing of Impairments - Adult Listings (Part A)

The following sections are applicable to individuals age 18 and over and to children under age 18 where criteria are appropriate.

[Evidentiary Requirements](#)

This electronic version contains the new Vision Listings under "Special Senses and Speech," effective February 20, 2007.

[Listing of Impairments
\(overview\)](#)

1.00
Musculoskeletal
System

New!
2.00
Special Senses and
Speech
Changes effective
2/20/2007

3.00
Respiratory
System

4.00
Cardiovascular
System

5.00
Digestive System

6.00
Genitourinary
System

7.00
Hematological
Disorders

8.00
Skin Disorders

9.00
Endocrine
System

10.00
Impairments that
Affect
Multiple Body
Systems

11.00
Neurological

12.00
Mental Disorders

13.00
Malignant
Neoplastic
Diseases

14.00
Immune System

Last reviewed or modified Friday Mar 02, 2007

Documenting Residual Functional Capacity

For patients whose impairments do not clearly meet criteria specified in one or more of the SSA Listings, medical professionals are encouraged to document (in collaboration with a multidisciplinary clinical team) functional limitations and activities the patient can or cannot perform despite those limitations. This information is necessary for SSA to determine a patient’s **residual functional capacity (RFC)** – the most the individual is still able to do despite functional limitations resulting from all of his/her impairments. Once established, the RFC is compared to the functional requirements of relevant work s/he has performed during the past 15 years. If the applicant is physically and mentally capable of doing work s/he has done in the past, the claim will be denied.

For example, although the obese patient does not qualify automatically under the medical Listings on the basis of obesity alone, s/he may qualify for benefits based on the functional consequences of her obesity. If s/he has knees that hurt so much s/he can’t stand for long, or dyspnea that keeps her from walking a block or two on level ground, she may qualify. But the disability examiner will want to know whether you sent her to physical therapy and whether she went, whether you have ordered pulmonary function tests and what they showed, and what therapies you have prescribed and what their effects were.

Past Relevant Work and Transferable Skills

If the applicant is not capable of doing work s/he has done in the past, DDS considers what other kinds of work s/he might be able to do. The individual’s vocational factors (age, education, and work experience) and RFC are compared with criteria specified in the **Medical-Vocational Guidelines (Grids)** included in SSA rules (20 CFR 404.1599; <https://s044a90.ssa.gov/apps10/poms.nsf/lrx/0425001001> (definitions)).

The “Grids” identify different **levels of exertional capacity** (sedentary, light, medium, heavy or very heavy) that are required for individuals of different ages, levels of education and past work experience to be determined disabled or not. Disability determinations depend on how well the “facts of the case” match criteria specified in the “Grids.”

SSA LEVELS OF EXERTIONAL CAPACITY

- **Sedentary work** generally requires sitting but may involve standing or walking for no more than 2 hours, with normal breaks, and in “most cases” good manual dexterity. It also requires lifting or carrying no more than 10 pounds and occasional lifting or carrying articles like docket files, ledgers, and small tools.
- **Light work** generally requires a good deal of standing and/or walking (approximately 6 hours a day), frequently lifting or carrying up to 10 pounds, and occasionally lifting or carrying no more than 20 pounds. Work may also fall into this category when it involves sitting most of the time with some pushing and pulling of arm or leg controls.
- **Medium work** involves frequent lifting or carrying up to 25 pounds, and occasionally lifting and carrying no more than 50 pounds.
- **Heavy work** (or very heavy work) represents substantial work capability for work in the national economy at all levels of skill and physical demand. In general, an individual who is able to do heavy work despite functional impairments will not meet the SSA disability standard.

SSA’s Medical-Vocational Guidelines (POMS DI 25025.005: <http://policy.ssa.gov/poms.nsf/lrx/0425025005>)

Documenting Disability: Simple Strategies for Medical Providers

Thus, it is critically important for health care providers to indicate in letters supporting disability claims of patients with severe impairments that do not meet or equal a medical Listing:

- How many hours during an eight-hour work day the individual can sit, stand, or walk (sedentary work requires the ability to sit for six hours and stand/walk for two; light and medium work require the ability to stand/walk for six hours); and
- How many pounds the individual can lift frequently (about 2/3 of the time) and occasionally (about 1/3 of the time).

This information should be provided even if it is not requested, and even if it is not called for in completing a DDS or SSA form.

AGE CATEGORIES SPECIFIED BY GRID RULES:

- Younger individuals – under age 50
- Closely approaching advanced age – 50–54
- Advanced age – 55–59
- Closely approaching retirement age – 60–64
- Retirement age – over 65

SSA's Medical-Vocational Guidelines (POMS DI 25025.005:
<http://policy.ssa.gov/poms.nsf/lnx/0425025005>)

In most cases, individuals under age 50 are determined disabled only if they can't do sustained sedentary work (as defined above). Older individuals and those with less education may require evidence of an impairment that prevents light or medium work. In general, disability is easier to establish for claimants who are older and have less education, less vocationally relevant past work experience, and a lower residual functional capacity.

Most SSI applicants over age 65 qualify for age based benefits without regard to disability. Nevertheless, because even old age SSI has an asset test, if a claimant over age 65 has more than \$2,000 in the bank, s/he will be denied on financial grounds. A few non-citizen SSI applicants are not eligible for age-based SSI but can qualify based on disability, even beyond age 65. SSDI applicants are eligible for reduced early retirement benefits beginning at age 62, but receive a higher benefit if able to prove disability before full retirement age. (Full retirement age is currently 65 years and ten months. It will gradually increase to age 67 in 2007 [<http://www.ssa.gov/retire2/agereduction.htm>].)

Persons who have only **nonexertional impairments** (impairments that do not limit the ability to lift, carry, stand, walk, sit, push or pull, including mental limitations) are evaluated under the criteria for heavy or very heavy work. For mental residual capacity, the evaluation turns on whether the individual can do simple, unskilled work on a sustained basis. The Grids are based on the availability of this kind of work. For persons with combinations of exertional and nonexertional limitations, the evaluation becomes more complex, but the Grids are still used as a framework to guide the disability determination.

Documenting Substance Use

People whose substance use is deemed material to their disability are ineligible for SSI/SSDI. The 1996 termination of SSI and SSDI eligibility for individuals whose drug addiction or alcoholism is material to their disability was not intended to disqualify persons disabled by co-occurring impairments that include substance use disorders. Such denials have nevertheless been widely reported to occur at the initial stage of disability determination, many of which are reversed to allowances at the appeals level. Lack of sufficient medical evidence of impairment attributable to other disorders can delay access to essential services for some people and deter others from pursuing disability claims further.

People with impairments that would remain severe if they discontinued substance use may qualify for SSI/SSDI. Individuals with substance use disorders who present sufficient medical evidence of impairment that meets SSA disability criteria are entitled to SSI/SSDI, regardless of their current alcohol or drug use. This guide is intended to help these disability applicants by educating clinicians how best to document impairments independent of active substance use. For a brief explanation of current DAA policy and exactly what kinds of evidence are required for persons with DAA disorders to qualify for SSI/SSDI benefits, read on. Information about the statutory basis of this policy, which clinicians may also find helpful, is available beginning on page 71.

Social Security Policy on Drug Addiction & Alcoholism (DAA)

Persons determined disabled by Social Security are not eligible for SSI/SSDI benefits if there is evidence that substance use is “a contributing factor material to the determination of their disability.” In other words, if there is medical evidence that an applicant’s impairments would not be severe enough to prevent substantial gainful activity (employment) if s/he stopped using alcohol or drugs, disability benefits would be denied. Only *after* SSA finds a claimant disabled, however, is the materiality of substance use considered. The Social Security Administration explicates its DAA policy as follows:

- (a) *General* If we find that you are disabled and have medical evidence of your drug addiction or alcoholism, we must determine whether your drug addiction or alcoholism is a contributing factor material to the determination of disability.
- (b) *Process* we will follow when we have medical evidence of your drug addiction or alcoholism.
 - (1) The key factor we will examine in determining whether drug addiction or alcoholism is a contributing factor material to the determination of disability is whether we would still find you disabled if you stopped using drugs or alcohol.
 - (2) In making this determination, we will evaluate which of your current physical and mental limitations, upon which we based our current disability determination, would remain if you stopped using drugs or alcohol and then determine whether any or all of your remaining limitations would be disabling.
 - (i) If we determine that your remaining limitations would not be disabling, we will find that your drug addiction or alcoholism is a contributing factor material to the determination of disability.
 - (ii) If we determine that your remaining limitations are disabling, you are disabled independent of your drug addiction or alcoholism and we will find that your drug addiction or alcoholism is not a contributing factor material to the determination of disability.

Source: 20 CFR §404.1535 [60 FR 8147, Feb. 10, 1995]; §416.935 [60 FR 8151, Feb. 10, 1995]

SSA POLICY ON DRUG ADDICTION & ALCOHOLISM

- **DAA is considered ‘material’** only when the medical evidence establishes that the individual would not be disabled if he or she stopped using drugs or alcohol.
- **“Medical evidence of DAA”** means that the evidence is from an “acceptable medical source” (see [DI 22505.003B.1](#)) and is sufficient and appropriate to establish that the individual has a ‘medically determinable substance use disorder.’
- **Medically determinable substance use disorders** are medical conditions described as “substance dependence” and “substance abuse” disorders in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (the DSM-IV) — conditions in which the individual's maladaptive pattern of substance use leads to clinically significant impairment or distress—not including medical conditions that arise from a mother's use of alcohol or drugs during pregnancy (e.g., fetal alcohol syndrome or “crack baby” cases).
- **An individual's own statement about his/her condition**, e.g., “I am an alcoholic” or “I am a drug addict,” is considered “evidence,” but [is] never sufficient and appropriate to establish the existence of DAA, even if that statement is reported by an acceptable medical source.
- **If there is no medical evidence of DAA**, no material determination is needed.
- **If DAA is material**, the individual cannot be considered to be disabled.
- **If DAA is not material**, the individual *can* be considered to be disabled.

SOURCE: Social Security Administration's Program Operations Manual System (POMS)
Section DI 90070.050 DAA Material Determinations.
<https://s044a90.ssa.gov/apps10/poms.nsf/lrx/0490070050!opendocument>

How SSA determines whether a DAA disorder is “material” to the disability or not:

CONSIDERATIONS IN MAKING A MATERIAL DETERMINATION

Adjudicators [are instructed by SSA to] take the following considerations into account when DAA is involved:

1. DAA Is Material Only When

SSA will make a finding that DAA is material only when the evidence establishes that the individual would not be disabled if he/she stopped using drugs or alcohol.

2. Key Factor to Consider

The key factor to consider when making a material determination is whether you would still find the individual disabled if he/she stopped using drugs or alcohol. In doing this, decide:

- Which of the current physical and mental limitations, upon which you based the current disability determination, would remain if the individual stopped using drugs or alcohol; and
- Whether any or all of these remaining limitations would still be disabling.

3. Examples of When DAA Is Material

The following are some examples of when DAA is material.

- a. The only impairment is a substance use disorder.
- b. The individual's other impairment(s) is by itself not disabling; e.g., a hearing impairment that is “not severe.”
- c. The individual's other impairment(s) is exacerbated by DAA and the evidence documents that, after a drug-free period of 1 month, the other impairment(s) is by itself not disabling.

SOURCE: SSA POMS DI 90070.050 DAA Material Determinations.
D. Process - Considerations in Making a Material Determination.
<https://s044a90.ssa.gov/apps10/poms.nsf/lrx/0490070050!opendocument>

These considerations also apply to “impairments caused by substance abuse, e.g., organic brain damage, liver problems, neuropathy. If the functional limitations caused by these impairments would remain if the substance abuse were to stop and are disabling alone or in combination with other impairments, the claimant is disabled independent of DAA and eligible for benefits” (Landry 2006).

DAA Policy Implementation and Impact

1. Inconsistent application

- Application of the concept of “materiality” varies from state to state, from Disability Determination Service (DDS) to DDS. Interpretation of this standard is extraordinarily difficult.
- Court rulings on appeals vary from state to state.
- Stigma about drug and alcohol use may influence some disability determinations.

Disability determinations and court rulings vary as adjudicators’ interpretations of the complex notion of materiality differ and rely upon subjective determinations (Perret 2006). Providers of Health Care for the Homeless and other advocates report widely varying application of DAA policy in various jurisdictions nationwide. Stigmatization of persons with substance dependence often results in the presumption of voluntary drug misuse and willful resistance to behavioral change. Federal legislation passed in 1996 (Public Law 104-121) resulted in new limitations on access to health care and material support for persons with behavioral health disorders (see Appendix I, p. 31). All of these factors create an unfavorable environment for SSI/SSDI claimants with substance use disorders, regardless of their co-occurring impairments.

2. The difference between DAA policy and scientific understanding of addiction

During the last 25 years, scientific research has begun to reveal the biochemical mechanisms by which mood-altering drugs – including caffeine, nicotine, alcohol, opiates, stimulants, and sedatives – change brain structure and function, thereby triggering addiction and dependence (compulsive drug seeking and use) in persons with particular neurological vulnerabilities. There is evidence that the biological changes persist long after drug use has ceased. From these findings has evolved the current theory of addiction as a chronic brain disorder with intrinsic behavioral and social-context components, similar to other forms of mental illness. (WHO 2004, CN 2006, CN 1998) Indeed, substance use has for decades been categorized as a mental disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV), the standard psychiatric reference used by mental health professionals worldwide.

The etiology of substance dependence, like many other health conditions, is a complicated blend of genetic, psychosocial, and environmental factors. Biologically, addiction is currently understood as a disorder of neurotransmission associated with the effects of certain drugs on particular parts of the brain. Significant scientific advances have been made in understanding the biology of addiction and the neurological effects of addictive drugs.

The view of substance dependence as a moral and legal issue may mean that treatment approaches and programs operated according to explicit public policy are not grounded in evidence-based research. This attitude is especially detrimental to people without homes (CN 2006, NLCHP 1999, CN 1998).

In addition, it is inconsistent with the traditional understanding of drug addiction or alcoholism as a public health problem.

- At least half of severely mentally ill homeless people are estimated to have a co-occurring substance use disorder.
- Substance use often exacerbates cognitive impairment over the long term, making recovery and response to traditional addictions treatment more difficult.
- Substance use disorders wreak havoc with personal finances and significantly increase other health risks – exposure to infectious diseases and violence, social isolation, and other hardships associated with extreme poverty.
- Co-occurring mental illness and substance use increase the likelihood of chronic homelessness. (CN 2000)

3. Impact of DAA Policy on personal and public health

1996 DAA policy changes resulted in:

- Limited or non-existent access to Medicaid in many states for persons who lost SSI benefits;
- Restricted access to treatment for substance abuse and co-occurring disorders;
- Increases in the incarceration of homeless people;
- High numbers of people in jail or prison with co-occurring disorders;
- Increased difficulty accessing employment for those with criminal drug convictions, even for possession;
- Limited or non-existent access to housing; and
- Increases in the incidence and duration of homelessness.

(Hunt and Baumohl 2003, NLCHP 1999)

4. Access to SSI/SSDI plays a role in preventing and ending homelessness

Lack of income, health insurance, and social support makes recovery from substance dependence virtually impossible for impoverished people. Access to appropriate housing and comprehensive, well-integrated, client-centered services provided by qualified staff is key to preventing and ending chronic homelessness for individuals with co-occurring impairments. Programs recognized for providing effective treatment to homeless people with substance use disorders consistently emphasize that a continuum of comprehensive services is needed to address their safety, health, social and material needs – including help obtaining food, clothing, stable housing, identification papers, financial assistance and entitlements, legal aid, medical and dental care, psychiatric care, counseling, job training, and employment services. (Kraybill and Zerger 2003)

Assisting individuals with SSI/SSDI and Medicaid applications prior to discharge from hospitals and jails can help to prevent homelessness. Programs that facilitate access to housing, income, and supportive services have demonstrated reductions in shelter and emergency department use, hospitalization and incarceration, as well as improved treatment engagement (Culhane et al. 2002; Zerger 2002). To the extent that DAA policy or its inappropriate implementation delays or impedes access to such services for people with substance use disorders and co-occurring impairments, it is contrary to best practices in preventing and ending homelessness (Dennis et al. 2007, CN 2005).

Co-occurring Disorders: Clinical Considerations

- **Practical Difficulties in Determining the Etiology of Impairment:** Clinically, it's extraordinarily difficult to determine which health conditions contribute to particular impairments. Multiple comorbidities that are characteristic of homeless individuals complicate diagnosis of the underlying cause(s) of disability. For example, cognitive impairment in a homeless patient with HIV may be indicative of AIDS-related dementia, depression, opportunistic infection, or a side effect of medication, including chronic "self-medication" with psychoactive substances. Symptoms of some diseases mimic organic brain disorders – e.g., confusion, incoherence, and distorted speech caused by very low blood sugar levels in patients with uncontrolled diabetes (CN March 2003). People with co-occurring disorders experience them simultaneously, interactively, and synergistically.

SSA acknowledges that it is often difficult or impossible to separate functional limitations resulting from drug or alcohol use from those resulting from other mental impairments and recognizes that *an individual should be found disabled when it is not possible to separate limitations* (DAA Q&A Teletype, EM-96200, <http://tinyurl.com/3nn4y>)

- **Use of Psychoactive Substances to Manage Trauma Sequelae:** Trauma – physical, sexual, and emotional – is both a cause and a consequence of homelessness, regardless of age or gender. Among the most serious cognitive disabilities seen in homeless people are those resulting from traumatic brain injury, commonly caused by vehicular accidents (being hit by cars), falls, assaults, gunshot wounds, and violent shaking. There is evidence that homeless individuals bear a disproportionate risk for severe head injury, which increases with prolonged homelessness (CN March 2003). Other cognitive impairments commonly seen in individuals who are homeless are associated with acquired brain injury secondary to mental illness, chronic substance abuse, infection, strokes, tumors, poisoning, or near drowning. In addition, a history of trauma, including sexual abuse as children and as adults, often leads to significant ongoing problems that interfere with functioning.

More than 90 percent of women seen by Health Care for the Homeless providers have experienced severe physical, sexual or emotional abuse by intimate partners or spouses, and 43 percent were sexually molested as children (CN May 2003). Physical abuse during childhood is a powerful risk factor for adult homelessness, and violence experienced by children and adolescents often continues after they become homeless. Those who are mentally ill or under the influence of drugs or alcohol are even more vulnerable to attack and less likely or able to seek help afterwards.

Documenting Disability: Simple Strategies for Medical Providers

There is a strong correlation between physical/sexual abuse and substance dependence among people who experience homelessness (CN 1999). Many of these individuals suffer from posttraumatic stress disorder (PTSD). Victims of trauma may use psychoactive substances to manage the overwhelming negative feelings that result from such abusive experiences. Experts in the care of trauma victims speak to the difficulty these clients have feeling safe, and homelessness exacerbates their feelings of insecurity. Addictive substances quell some of these feelings, even if temporarily.

These are some of the reasons why co-occurring mental health and substance use disorders are more common among homeless than housed populations (Perret 2006).

Beginning at age 8, Mr. M. used medications and liquor found in his home to cope with the severe physical, emotional, and sexual abuse he experienced as a young child. “I took whatever was around to get me into my dream world — that’s what helped me to survive what happened to me as a child.” His addiction masked not only psychological trauma but also undiagnosed mental health issues he only learned about when he stopped using [addictive substances], two decades later. Mr. M. describes how his trauma affected his recovery: “...[When I stopped using drugs,] those feelings would start coming up again. I started feeling like my perpetrator was in the room.”

– HCH Clinicians’ Network. *Addiction on the Streets; October 2006 Healing Hands*

Recommendations for Clinicians

1. When to support/encourage a SSI/SSDI application by an individual with a DAA disorder:

- *Support disability claims submitted by persons with substance use disorders if there is evidence that their impairments meet or medically equal the criteria of a medical listing¹³ or prevent them from engaging in substantial gainful activity (or, in a child, result in comparable functional limitations), and the impairment is likely to remain if the patient were to stop using alcohol or other drugs.*
- *Advise such persons to apply for SSI/SSDI if they have not already done so.* Some clinicians wrongly believe that people who are actively using psychoactive substances cannot or should not receive Social Security benefits, despite any other disabilities they may have, and erroneously discourage them from applying (Rosen and Perret 2005). Individuals with impairments that meet SSA disability criteria independent of active substance use are eligible for SSI/SSDI benefits. Empirical research suggests that “few, if any, adverse effects result from providing federal disability benefits to persons with addictive disorders” (Frisman and Rosenheck 2002).

Several research studies conducted over the past decade have demonstrated that people with addictive disorders who receive Federal disability payments are *not* more likely than those engaged in gainful employment to purchase alcohol or drugs or to increase their substance use, and that SSI/SSDI benefits can significantly improve their quality of life (Frisman and Rosenheck 2002, Rosen et al. 2006).

2. Providing medical evidence of impairment:

- *Make sure that medical records submitted to SSA specify one or more diagnoses made by a medical professional.* An applicant without evidence of an independent diagnosis from an acceptable medical source will be denied benefits (Rosen and Perret 2005). (An “acceptable medical source” is defined on page 20.)
- *Ensure that functional impairments and medical diagnoses are thoroughly described in the material submitted to SSA/DDS.* Typically, medical records do not provide sufficient evidence of functional impairment to support a disability claim based on mental impairment. Clinical staff should work collaboratively to describe such functional impairment, its linkage to the claimant’s medical disorders, and how the impairment affects the person’s ability to engage in substantial gainful activity (i.e., employment).

¹³ as specified in SSA’s Medical Listing of Impairments: <http://www.socialsecurity.gov/disability/professionals/bluebook/>

3. Discussing substance use in letters to SSA supporting disability claims:

- ***Address any medical evidence of a substance use disorder explicitly in your letter to SSA.*** Substance use is commonly documented in homeless patients' medical records. References to substance use are often found in emergency room and specialist notes even for nonusers, due to the strong prevailing stereotype that all homeless people have drug and alcohol problems (O'Connell et al. 2004). Failure to mention a known history of substance use may undermine the credibility of the medical source. When substance use is involved, determination of disability is confounding for both DDS adjudicators and administrative law judges, especially when the clinical analysis of the claimant's substance use and co-occurring impairments is unclear. This lack of clarity often leads to incorrect eligibility denials. It is critical, therefore, to address explicitly how impairments that are unrelated to active substance use affect the claimant's ability to work.
- ***Advise SSI/SSDI applicants to be candid about past or current drug/alcohol use.*** Many applicants fear their claim will be denied if they admit drug or alcohol use. However, any inconsistency between oral accounts and medical records could undermine the applicant's credibility. This can result in a finding of "not disabled." Assure the applicant that it is possible for SSA to make a correct disability determination when given thorough, accurate, and complete medical and functional information. (Rosen and Perret 2005)
- ***Recommend a Representative Payee and assure that one is available.*** If the applicant is considered incapable of managing his or her own SSI/SSDI benefits or is at risk of spending cash payments on alcohol or drugs, recommend in a letter to the Social Security Administration that s/he be required to receive cash benefits through a Representative Payee. Well-run charitable or public agencies may be preferable as payees for such individuals, who are easily victimized. (For more information about the Representative Payee Program, see <http://www.ssa.gov/payee/>; Rosen and Perret 2005, 75-81.) Besides asserting the need for a payee, it is critical to assure the availability of programs that provide such a service. Recommending a payee without ensuring access to one is futile.

4. Documenting impairment independent of active substance use:

When a person is determined disabled, considering all impairments, and there is evidence of alcoholism or drug addiction, SSA must decide whether that person would still be disabled if drug or alcohol use stopped.

Chronic and irreversible medical illnesses and fixed functional deficits that result from the use of alcohol and other substances may qualify as eligible impairments. Examples include cirrhosis, cardiovascular disease, organic brain syndrome secondary to alcohol use, and loss of limb function from infections related to intravenous drug use. Medical providers can effectively support such disability claims by providing evidence of co-occurring impairments that would not disappear even if the individual were sober and abstinent from alcohol and drug use.

For claimants who are actively using psychoactive substances:

- **Take a comprehensive longitudinal history.** Ask the patient about issues such as trauma, abuse, education and learning problems, employment history and problems, legal history, emotional and physical health (Rosen and Perret 2005). (For guidance in asking these questions, see Bonin et al. 2004.) Comprehensive histories are essential to understand the context of an individual's substance use and factors that may influence such use. Elicit this information sensitively, with open-ended questions that allow for elaboration.

Avoid words that label, such as “sexual or physical abuse,” since victims of abuse may not understand such experiences in this way. Questions such as “What happened when you did something growing up that was considered naughty?” can help elicit information about abuse without having to name it as such. Ask if the individual was ever in foster care, which is a significant predictor of risk for post-traumatic stress disorder (see Pecora et al. 2005). Explore learning problems, not just years of education completed. To understand the extent to which substance use may or may not contribute to the individual's impairments, learn more about his or her personal history.

- **State whether or not there is reason to conclude that the individual's impairment(s) would resolve if substance use ended,** and report all irreversible adverse effects of this problem. If it is impossible to determine whether a patient's impairment(s) would be reversible with abstinence, state this explicitly.

For individuals with chronic pain or mental health disorders:

- **It is helpful to state that alcohol and drug use may represent attempts at managing symptoms of the underlying illnesses,** particularly if the medical provider making this statement has observed the patient over an extended period of time (Ibid.). Roles that substance use can play in “self-medicating” underlying mental illness include: energizing persons with major depression, reducing manic and depressive symptoms of bipolar disorder, suppressing voices and other psychotic symptoms associated with schizophrenia, and repressing and anesthetizing overwhelming feelings caused by trauma or PTSD. Describing the sequelae of trauma that many homeless people have experienced and continue to experience can provide a context for substance use that is important for DDS to understand. It is important that your reports to DDS include such details. (Perret 2006)
- **Ask the claimant whether reported problems occur when s/he is sober or only when using alcohol or drugs.** For example, if a person states that s/he takes substances to dull the fear and discomfort created by hallucinations, the clinician could conclude that the mental disorder is the problem and that the symptoms are likely to remain, even in the context of abstinence from drugs. Conversely, if an individual reports that s/he manages activities of daily living fairly well while sober but avoids these tasks when using or withdrawing from substances, this person might be found not disabled (i.e., ineligible for SSI/SSDI). (Rosen and Perret, 2005)
- Since addiction is a brain disease marked by recurrent relapses, it is helpful to **document the claimant's physical and mental status during periods of abstinence.** Such periods may occur

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during recovery, with or without treatment. Periods of abstinence may also occur during incarceration or hospitalization.

- If the claimant has relapsed at the time of assessment, it is also helpful to *comment on any additional damage sustained during the current relapse* (Ibid.).

Clinicians and others who work with homeless people are well aware of the extent of substance use in this population. A comprehensive understanding of substance use and its relationship to other disorders and impairments is critical to the appropriate documentation of disability in support of SSI/SSDI claims.

Readers are invited to consult the bibliography for more comprehensive information about the diagnosis and treatment of individuals with co-occurring substance use disorders and mental impairments (see especially Zerger 2002, Kraybill and Zerger 2003, CSAT 2006). In addition, the National Health Care for the Homeless Council encourages primary care practitioners to seek further training in the care of individuals with substance use disorders (see the American Society of Addiction Medicine for more information: <http://www.asam.org/>).

No matter how strong one's belief in the importance of abstinence or sobriety, remember that SSI is an entitlement program that should be available to all persons meeting SSA disability criteria, and that SSDI is an insurance program that presupposes a history of work to which beneficiaries have already contributed in some measure through payroll taxes. Too many homeless people with disabilities do not get the assistance they urgently need.

Special Considerations

Adverse Profiles

Adverse profiles are special circumstances with regard to past relevant work and transferable skills. According to SSA regulations, there are two medical-vocational profiles that show an inability to adjust to other work and warrant a finding of “disabled.” Disability claims of individuals with a 6th-grade education or less and 35 years of **arduous unskilled labor** who have a severe impairment that prevents past work will be approved. Claims of individuals aged 55 or older with a severe impairment and less than an 11th-grade education who have **no substantial work experience** will also be approved (POMS DI 25010.001B: <http://policy.ssa.gov/poms.nsf/lnx/0425010001>).

Somatoform Disorders

Somatization is defined by the lack of objective findings upon examination. Patients may be markedly impaired by their overwhelming experience of illness, but their symptoms may or may not be consistent with expected symptoms from a named disease or syndrome. Nevertheless, it is important not to dismiss these patients as malingering. *Malingers are by definition aware of symptom generation; persons with somatoform disorders are not.*

Somatization is very common in patients with behavioral health problems such as depression, anxiety disorders, posttraumatic stress disorder, personality disorders, alcoholism, or stimulant abuse. Somatoform disorders also co-exist with recognized medical conditions, but symptoms may be out of proportion to expected or normal responses. Symptoms can interfere with work and have been reported to persist over 12 months.

It is entirely appropriate for primary care providers to report to SSA manifestations of mental illness, which they have been trained to recognize. Documenting objective findings in support of patients’ subjective complaints is essential in effective disability evaluation reports.

MEDICAL LISTING FOR SOMATOFORM DISORDERS

12.07 Somatoform disorders: Physical symptoms for which there are no demonstrable organic findings or known physiological mechanisms.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented by evidence of one of the following:

1. A history of multiple physical symptoms of several years duration, beginning before age 30, that have caused the individual to take medicine frequently, see a physician often and alter life patterns significantly; or
2. Persistent nonorganic disturbance of one of the following:
 - a. Vision, or
 - b. Speech; or
 - c. Hearing; or
 - d. Use of a limb; or
 - e. Movement and its control (e.g., coordination disturbance, psychogenic seizures, akinesia, dyskinesia; or
 - f. Sensation (e.g., diminished or heightened).
3. Unrealistic interpretation of physical signs or sensations associated with the preoccupation or belief that one has a serious disease or injury;

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation, each of extended duration.

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In providing evidence for disability claimants with a somatoform disorder, it is important to demonstrate impairments that result from the disorder. The required level of severity for these disorders is met when the requirements in both A and B of the medical listing for Somatoform disorders (12.07) are satisfied.

If both of these criteria are not met, focus on functional limitations and residual functional capacity:

- Document clearly and by example, if possible, the marked restriction of activities of daily living,¹⁴ marked difficulties in maintaining social functioning, and marked difficulties in maintaining concentration, persistence, or pace; and, if present, repeated episodes of decompensation.
- Document the presence of multiple physical complaints, quantify the number of medical visits, and document episodes of poor patient-physician relationship.
- When somatization accompanies another diagnosed mental health disorder, recognize and document it.
- In patients with a somatoform disorder, document poor or guarded prognosis for improvement.
- Evidence of a long pattern of illness and early onset supports a somatoform diagnosis. Use outside observed information if possible.

It is important not to confuse somatoform disorders with malingering. Although malingering is occasionally suspected in homeless patients, other explanations for their behavior must also be considered. For example, one patient complained of back pain so severe that he could barely stand up. He was later seen getting on and off a bus and walking down the street without difficulty, when he didn't know he was being watched. This was reported in the letter supporting his disability claim. His behavior was reported within the context of a severe personality disorder, which was, in the opinion of the treating physician, the primary source of his impairment. The patient was awarded a disability benefit.

In many places across the country, SSA has stepped up its investigations of fraud and abuse. Clinicians are advised to document any discrepancies in patient complaints and behaviors within the context of all medical and mental health conditions that impair functional capacity.

Groups Barred from Federal Disability Benefits

Clinicians should be aware that **undocumented immigrants, incarcerated persons, fugitive felons, and probation or parole violators are barred from receiving federal disability benefits.**

Immigrants (non-citizens)

¹⁴ Activities of daily living (ADLs) include: bathing, dressing, eating, mobility, transferring, and toileting. Instrumental Activities of Daily Living (IADLs) include: meal preparation, medication management and administration, money management, telephone use, transportation, employment, shopping, and housework. (CDC. Current Trends Prevalence of Disabilities and Associated Health Conditions ~ United States, 1991-1992; MMWR October 14, 1994 / 43(40); 730-731,737-739: <http://www.cdc.gov/mmwr/preview/mmwrhtml/00033002.htm>)

Welfare and immigration laws passed in 1996¹⁵ restrict access to SSI and SSDI based on a person's immigration status.

- **Undocumented immigrants** (who are not legally residing in the U.S.) are ineligible for SSI. In general, only legal immigrants who are exempt from bars on Federal assistance may qualify for SSI. Like other U.S. citizens, naturalized citizens and all children born in the U.S. (including those born to undocumented immigrants) may qualify for SSI and/or SSDI if they meet SSA's non-medical and medical disability standards (summarized above).
- Noncitizens who are **legal immigrants** (also called qualified or documented aliens) are people born in a foreign country who have been legally admitted to reside in the U.S. They may be eligible for SSI if they were blind or disabled or receiving SSI on 8/22/96, if they are permanent residents with a total of 40 credits of work in the U.S. (which may include a spouse's or parent's work), or if they are members of one of the following "exempt" groups:
 - Veterans or active duty members of the U.S. armed services who are qualified aliens and the spouses and children under 21 of these service members
 - American Indians born outside the U.S.
 - Certain noncitizens admitted as Amerasian immigrants
 - Cuban or Haitian entrants
 - Refugees and asylees¹⁶ during the first seven years after entering the U.S. and obtaining this immigration status.
 - Those granted withholding of deportation during their first five years after entering the U.S.

Income and resources of all legal immigrants with a sponsor (someone who signed an affidavit of support when they entered the U.S.), must be deemed to include the income and resources of their sponsors and their sponsors' spouses. These "deeming" provisions make it extremely difficult for such immigrants to meet income eligibility requirements for SSI or Medicaid.

(Sources: SSA, *Supplemental Security Income (SSI) For Noncitizens*: <http://www.ssa.gov/pubs/11051.html>; National Immigration Law Center: www.nilc.org/pubs/guideupdates/tbl1_ovrww_fed_pgms_032505.pdf)

Incarcerated persons

People who have qualified for SSI or SSDI usually cannot receive benefits while residing in a "public institution" (jail, prison, hospital, or mental health treatment center). The two disability programs have different requirements regarding whether and how benefits can resume following release. (There is an exception for SSI recipients who are hospitalized. If their doctor can attest to their expected discharge from the hospital within 90 days and attest that the individual needs SSI to maintain housing,

¹⁵ The Personal Responsibility and Work Opportunity Reconciliation Act (Also known as PRWORA or the Welfare Reform Act) of 1996 (Public Law 104-193) and the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (Public Law 104-208)

¹⁶ Refugees and asylees are people seeking protection from the U.S. on the grounds that they fear persecution in their homeland, based on their political opinion, national origin, or membership in a social group, religion or race. A *refugee* generally applies for protection from a place outside the U.S.; an *asylee* applies for protection after coming to the U.S.

SSI benefits can continue for up to 90 days. If the person is not discharged within 90 days, there is no penalty to the individual.)

- **Suspended versus Terminated Benefits** Whether *SSI benefits* are suspended or terminated depends on the length of time a person is incarcerated. When incarceration lasts for a full calendar month but *less than 12 consecutive months*, benefits are suspended. Monthly payments can resume after SSA is informed of the person's legal release and confirms that s/he still meets financial requirements only (disability does not have to be proved). When incarceration lasts *12 months or more*, benefits are terminated. A completely new application must be filed upon release, showing that the individual still meets all Federal disability standards.

SSDI benefits are suspended following felony conviction and incarceration post-conviction for 30 days or longer, but are not terminated, no matter how long the individual is confined, so long as s/he continues to meet the Federal definition of disability (confirmed by continuing disability reviews performed at specified intervals which are established at the time of approval). Release from the correctional facility must be verified before payments can resume. If a worker's dependents qualify for SSDI, payments are not suspended or terminated while the worker is in jail.

- **Pre-release Agreements** Jails, prisons, and hospitals can enter into pre-release agreements with the local Social Security office to expedite applications and reapplications for SSI. When such an agreement exists, SSA processes claims more quickly, inmates have assistance in gathering information needed to support their application, and benefits are often payable immediately upon release or shortly thereafter. An additional advantage is that a pre-release agreement is often allows for applications to be submitted more than 30 days (the standard application time period) prior to release.
- **Disability Applications during Incarceration** Inmates not receiving benefits when sent to jail can apply for SSI or SSDI while incarcerated, in anticipation of their release. An application is more likely to be successful if the prisoner is residing in an institution that has a pre-release agreement with SSA and has been identified by the institution as nearing release and likely to be disabled. Incarcerated persons usually need assistance to obtain the appropriate forms and gather the necessary evidence, and should apply as long as possible before their release date, so that payments can begin as soon as possible following release. Normally, review of an application takes about three months. If the application is approved before the inmate's release, payments will begin on the first day of the calendar month following release. If the application is approved after the inmate is released, SSI (but not SSDI) benefits are backdated to the first day of the month following release.

(Source: Bazelon Center for Mental Health Law: *Arrested? What Happens to Your Benefits If You Go to Jail or Prison? A Guide to Federal Rules on SSI, SSDI, Medicaid, Medicare and Veterans Benefits for Adults with Disabilities*: www.bazelon.org/issues/criminalization/publications/arrested/index.html)

Fugitive Felons & Probation/Parole Violators

Fugitive felons and probation/parole violators are ineligible for SSI & SSDI benefits. The Social Security Act states that an individual who has qualified for SSI will not receive payments in any month during which s/he is “fleeing to avoid prosecution, or custody or confinement after conviction ... for a crime, or an attempt to commit a crime, which is a felony under the laws of the place from which the person flees ... or violating a condition of probation or parole imposed under Federal or State law.” (42 U.S.C. § 1382(e)(4)(A) and (B)). The fugitive felon disqualification was extended to SSDI recipients by Congress, in the Social Security Protection Act of 2004, effective January 1, 2005 (42 U.S.C. §402(x)(1)(A)(v) , <https://s044a90.ssa.gov/apps10/poms.nsf/lrx/0202613001>).

The statute requires a **specific intent to flee**, however, and cannot be invoked just because an individual, for whatever reason, fails to appear for prosecution or for custody or confinement. There must also be a **warrant** issued on the basis of an appropriate finding that the individual is fleeing, or has fled to avoid prosecution, custody, or confinement (20 C.F.R. § 416.1339(b)(1)(i)).

SSA sometimes wrongly applies the disqualification to anyone with an outstanding felony warrant, even to those who are unaware of the warrant. Most such warrants are issued on the basis of a simple failure to appear and are unlikely to contain a finding as to the reason for the failure to appear. Among SSI & SSDI recipients denied benefits under the “fugitive felon” statute, most are persons with severe mental illness or cognitive impairment, and it is likely that a disproportionate number are homeless people. (For information about how advocates can find relief for homeless clients who are neither fugitives nor felons, see McIntyre 2003.)

(Sources: National Senior Citizens Law Center (NSCLC). “Fugitive Felon” Penalty: http://www.nsclc.org/areas/social-security-ssi/area_folder.2006-09-26.2745496389; and McIntyre 2003: http://www.lanecountylegalservices.org/Have_you_seen_a_fleeing_felon.pdf)

LETTER WRITING GUIDELINES

Requests for clinicians to write letters documenting medical impairments may come from patients, attorneys or case workers at the time of initial application, or may come from SSA or the State's disability determination services as it investigates an applicant's claim. The following guidelines for such letters are derived from an advocate's guide prepared by Peter H. D. McKee and from a curriculum for medical providers prepared by Paul Quick, M.D, Barry Zevin, MD, and Masa Rambo, FNP.¹⁷

1. **Review** the Listing of Impairments for each health problem that your patient has. Note the clinical findings and symptoms of each relevant impairment delineated in the Listing.
2. **Compare** the clinical findings and symptoms specified in the Listing with the findings recorded in your patient's medical record by you or any other medical provider.
3. **Write** a specific letter that
 - Gives your general past history of treatment and dealings with the patient; and specifies the length of your relationship and whether you are the treating physician;
 - Provides a candid observation of the severity and duration of the patient's impairments, documenting his/her relevant work history, age, height, weight, vital signs, relevant measurements, and physical examination results;
 - Gives objective evidence of the patient's impairments, one at a time, as defined by the Listing of Impairments, and compares exact findings or symptoms of the relevant listed impairment with the specific findings or symptoms of your patient;
 - Uses the recognized medical terms or measurements described in the age-appropriate Listing of Impairments;
 - If criteria for a listed impairment are not met, specifies the patient's functional limitations secondary to all specified disorders, how long they have lasted and are expected to last, the patient's ability to do basic work activities, and any special circumstances (whether the patient fits an adverse profile);

¹⁷ *An Advocate's In-Depth Guide to Social Security Disability and Medical Letter Guide*, prepared by Peter H. D. McKee, JD (Douglas, Drachler & McKee, LLP, 1904 3rd Ave., Ste 1030, Seattle, WA 98101; e-mail: PHDM@Qwest.net); PowerPoint presentation by Paul Quick, MD, Tom Waddell Health Center, San Francisco Department of Public Health (3/13/03). For examples of letters documenting impairments related to serious mental illness, readers are also referred to a publication by the Substance Abuse and Mental Health Services Administration: *Stepping Stones to Recovery: A Training Curriculum for Case Managers Assisting People Who Are Homeless to Apply for SSI/SSDI Benefits*, prepared by Jeremy Rosen and Yvonne Perret (2005).

- Closes with a summary statement specifying what listing(s) is/are met or how the Listings are equaled, given all functional limitations taken together; and
 - Is signed by an acceptable medical source (see page 20) with title and relevant certifications (e.g., board certified, academic credential or other special qualifications). If the letter is written by a nurse practitioner or other provider, it should be co-signed by an acceptable medical source with statement of that person's involvement.
4. **Attach** all relevant chart notes and progress notes to the letter.

EXAMPLES OF LETTERS SUPPORTING SUCCESSFUL DISABILITY CLAIMS

The following letters were written by medical providers working in Health Care for the Homeless projects in three different regions of the United States. The patients they describe were all awarded disability benefits based on the evidence provided by these clinicians. Each letter represents a slightly different strategy from the others.

- **Letter 1** specifies a medical listing met by the patient’s impairment and work-related functional limitations that resulted from it (p. 44).
- **Letter 2** details evidence to support the conclusion that a medical listing of impairment is met in the “mental disorders” listing. Presenting such evidence is critical; merely stating that the claimant meets a listing is insufficient in many jurisdictions. The evidence documented is fairly easily accessible to Health Care for the Homeless providers, documenting behavior and the results of poor social functioning and judgment. (p. 45)
- **Letter 3** focuses on two medical Listings as the primary basis for disability determination. This letter uses a medical consultation style that is comfortable for many clinicians. It uses several compelling details to eloquently communicate the severity of the patient’s impairment. (p. 48).
- **Letter 4** documents multiple impairments which together are equivalent in severity to a Listing, and describes the patient’s residual functional capacity (p. 50).
- **Letter 5** focuses on functional limitations as the basis for disability determination, since the impairments described neither meet nor equal a medical Listing. This is an example of a letter written by a nurse practitioner in collaboration with a physician. (p. 52).
- **Letter 6** establishes the treating source’s long-term relationship with the claimant, adding credibility to his observations regarding the relationship between the claimant’s substance use and his psychiatric impairments. The physician recommends use of a Representative Payee if disability benefits are awarded. (p. 54)
- **Letter 7** is a good example of the differentiation of effects of the patient's alcohol use from his other presenting issues. Although the impact of alcohol use on the applicant's physical and mental conditions is certainly powerful, the physician clearly outlines the other causes of disability; he is also careful to state explicitly that that his patient would be disabled (and has, in fact, remained disabled) during periods of sobriety. (p. 55)
- **Letter 8** addresses the issue of separating the effects of the claimant’s substance dependence from his co-occurring impairments, in the absence of known periods of sobriety. The fact that the author is a certified specialist in Addiction Medicine adds weight to his opinion that the client’s “health seeking behavior...is atypical for patients primarily with stimulant dependence as their diagnosis,” supporting the conclusion that the patient’s Bipolar disorder and personality disorder, in addition to his chronic back pain secondary to an untreated spinal condition of long standing, are primarily responsible for his disability.¹⁸ (p. 56)

¹⁸ The disability claims described in letters 6–8 were sent to an administrative law judge known to be very strict in his rulings on claims involving DAA issues. The treating physician provided information at the appeals hearings as an expert in addiction medicine, reiterating information contained in his letters to DDS. Disability benefits were ultimately awarded.

- **Letters 9 & 10** have been abbreviated to emphasize the documentation of functional impairment independent of substance use (pp. 59–61). They offer an especially good illustration of documented activities of daily living. Because DDS adjudicators rarely interview or even see applicants, it is important that supporting documentation offer as clear a picture as possible of the impact of the claimant’s impairments on day-to-day functioning.

The physicians who composed and/or signed these letters made the following observations:

- **There is a significant amount of regional variation in how disability determination agencies work.** Some DDSs rely on treating sources more than others to identify medical Listings that are met or equaled by a claimant’s impairment(s). In Boston, for example, providing evidence that an impairment meets or is equal in severity to a Listing is sufficient for the DDS to determine the claimant disabled; no additional discussion of functional limitations is necessary. In San Francisco, some discussion of functional status is required in addition to presentation of evidence that a Listing has been met, particularly for patients with HIV or mental impairments.
- **Many medical providers do not feel competent to describe their patients’ functional impairments.** They are more comfortable specifying impairments that meet one or more medical Listings. Although this is the simplest way to document disability, not all patients have disabling conditions that meet or equal a medical Listing, yet many still qualify for SSI/SSDI based on medical-vocational considerations (26.9 percent of allowances in FY 2004).

“Physicians who work at the disability determination agencies or who testify as medical experts at Social Security hearings routinely rate the applicant’s ability to sit, stand, walk, lift, carry, and meet the functional requirements of work — based on a review of treatment records and without the advantage of ever having seen or spoken with the applicant. The law recognizes that any conflict between the functional assessment of a treating physician and the assessment of a non-examining physician should generally be resolved in favor of the treating physician. Therefore, treating physicians should be urged to describe their patients’ functional limitations to the extent possible.”

— David Ettinger, JD, *Legal Aid Society of Middle Tennessee and The Cumberland*

Although describing patients’ functional limitations can be challenging for medical providers alone, working as part of a multidisciplinary clinical team that includes social workers/case managers and/or vocational counselors can facilitate this process. It is sometimes easier in the case of homeless applicants who must rely upon charitable organizations for all meals, shelter, and clothing. Some providers ask their clinical staff whether they would want to depend on the claimant for a job they counted on, and if not, why they would not want this person to work for them. This helps to stimulate thinking about what the patient’s functional incapacity is.

LETTER I

November 12, 2004

Re: L J

SS# xxx-xx-xxxx

To Whom It May Concern:

I am writing this letter on behalf of L J, a patient of mine at the Austin Cook County Health Center, in support of her claim for disability. She has been a patient at our health center since 5/99 and my patient since 11/00. She has been seen in the clinic an average of 5 times a year during that time period.

Ms. J had a central nervous system cerebro-vascular accident on July 6, 2004 which has left her with significant persistent deficits in right arm and right leg. Her impairments include the following:

Gait and Right lower extremity: She has an unsteady gait that has made her unable to walk safely at a constant rate on a treadmill with the physical therapists. Her therapy goal was to walk on a level treadmill at three miles per hour for 10 minutes. She could not keep herself centered on the treadmill and would have fallen repeatedly had she not been supported by the hand rails. She was unable to walk for more than two minutes at a time. Her right hip flexion strength is 3/5. She steps to the right when trying to walk with her feet in tandem.

Right upper extremity: Ms. J is right handed. She carries her right arm in a flexed posture when walking. Her right upper extremity strength is 3/5 in flexion and extension at the elbow, and 3/5 in shoulder abduction. She has mildly reduced rapid alternating movements with her right hand and severely reduced ability to write or sign her name. She also has subjective numbness throughout her right arm and moderately reduced ability to identify objects placed in her right hand. She can not carry anything of significant weight (over 2 pounds) in her right hand.

In my opinion, L J is permanently disabled as a result of her stroke. She meets Social Security listing **11.04** as described in the online Blue Book. She has significant and persistent (over 3 months) disorganization of motor function in 2 extremities (right arm and right leg) resulting in sustained disturbance of gross (inability to carry objects) and dexterous (inability to write) movements or gait and station (her gait is abnormal and unsteady).

L J also meets the functional requirements for a musculoskeletal listing described at section 1.00 of the listings. She requires a walker for distances as short as a single block and cannot sustain effective ambulation. Her use of the right arm is so restricted that she cannot prepare a simple meal or feed herself without assistance.

During an eight-hour work day, L J could stand or walk no more than one hour. She can sit without limitation. She is not limited in the ability to lift with her left arm, but she can lift no more than two pounds with her right arm.

L J has not had a mental evaluation since her stroke, but she has complained of memory loss and an inability to concentrate. If her disability claim cannot be favorably resolved based upon her physical limitations, I would recommend that a neuropsychological evaluation be obtained.

If you have any additional specific questions about her condition, please let me know. I am enclosing copies of my relevant treatment records.

Sincerely,

David Buchanan, MD
Attending Physician
John Stroger Hospital of Cook County
Board Certified in Internal Medicine
Assistant Professor, Rush University

11.04 Central nervous system vascular accident. With one of the following more than 3 months post-vascular accident:

A. Sensory or motor aphasia resulting in ineffective speech or communication; or

B. Significant and persistent disorganization of motor function in two extremities, resulting in sustained disturbance of gross and dexterous movements, or gait and station (see 11.00C).

*Listing of Impairment cited in the preceding letter
Source: 2006 SSA Blue Book*

LETTER 2

February 22, 2006

To Whom It May Concern:

I am writing this letter in regards to Mr. J. S., Case # 111111 and SS# 111-11-1111. This letter is intended to give the Social Security Administration information regarding Mr. S's current status as it relates to his application for SSI. I am currently Mr. S's Treating Source. We have had an ongoing treatment relationship since February 2005. I have also consulted on this case with Mr. S's former therapist George Gilman, LCSW and his Case Manager, Jennifer Alfredson, APSW. Mr. Smith was admitted into the Health Care for the Homeless Case Management Program in August 2005.

Mr. S. is not currently engaging in any Substantial Gainful Activity.

Mr. S. was diagnosed with Bipolar Disorder Type I by myself, Dr. Steven Ortell, in February 2005. Prior to February 2005, Mr. S's mental impairments were undocumented. Mr. S. had been living in the woods, outdoors, since 2002 and was not seeking any treatment for what he described as problems with his thinking. He was engaged by the Health Care for the Homeless – Street Outreach. He agreed to begin seeing a psychiatrist at Health Care for the Homeless' Recovery Behavioral Health Clinic. He also agreed to begin working with the Red Cross Outreach Nurse and was referred to a Safe Haven Shelter.

Mr. S's impairments became clearer once he was staying at Safe Haven, where they have only 8 residents and staff present 24 hours a day. Ms. Alfredson was able to inform this writer about the occurrences at Safe Haven. Mr. S. did not respond appropriately to the supervision at Safe Haven. He did not get along with other residents or the staff and mostly stayed to himself. He had trouble understanding that his situation differed from the other residents. He would become very irritable when comparing his situation to others and would ask why he can't get a bus pass or other things that residents with income had access to. He expressed paranoia about the other residents and the staff. He demonstrated an irritable and labile mood that inhibited his ability meet the expectations of staff in the area of household chores and/or keeping his room in order. Mr. S. demonstrated poor judgment when he had trouble following the rules and was eventually asked to move out due to his chronic non-compliance with the curfew of 10 PM. When Mr. S. left the Safe Haven in September 2005, he went back to living in the woods, outdoors. He was quite upset about the consequence of his poor judgment. I think that Mr. S. does demonstrate a severe impairment.

I think that Mr. S. does meet the criteria listed in the Social Security Blue Book, section 12.04 for Affective Disorders. Mr. S. does have a disturbance of mood, accompanied by partial manic and depressive symptoms. Mr. S. meets the criteria of 12.04 (A) in the following way: Mr. S. has depressive symptoms that were first assessed and documented in February 2005. Mr. S. reported a loss of interest in all activities, a sleep disturbance, feelings of guilt and worthlessness, difficulty concentrating and feeling very paranoid. Mr. S. avoids public transportation due to paranoia and is extremely guarded with Outreach Workers and most other staff that he has come into contact with since being engaged by the Outreach Worker. Mr. S. has also experienced symptoms of mania. Mr. S. has been observed to have pressured speech, flight of ideas, and he is easily distracted. He also gets involved in activities that have negative consequences, such as fighting with people on the streets have led to both injury and incarceration. Again, Mr. S. reports feeling very paranoid. As a result of the previously described impairments, Mr. S. was diagnosed with Bipolar Disorder and has had periods manifested by the full symptomatic picture and currently is characterized by both depressive and manic symptoms.

And, Mr. S. meets the criteria of 12.04 (B) in the following way: Mr. S. evidences a marked restriction of activities of daily living. Most notably, Mr. S. has been unable to maintain a residence since 2002. Since that time, he has been living outdoors in a wooded area on the East side of Milwaukee. Mr. S. does not appropriately care for his personal grooming and hygiene. His appearance is usually odorous, his clothing dirty, and his hair appears dirty and unruly. Mr. S. has not had the opportunity to demonstrate the ability to pay bills, cook, or shop due to his having no income and living outdoors. When Mr. S. was living at Safe Haven from July until September 2005, his grooming and hygiene did improve somewhat. At the Safe Haven, he still did not have the opportunity to cook or shop. Mr. S. also avoids public transportation due to his paranoia, which then causes anxiety.

Mr. S. has marked difficulties in maintaining social functioning. Mr. S. has demonstrated that he is unable to interact appropriately with other individuals. Mr. S. does not have any relationships with any of his family, which includes his father and six living siblings. Mr. S. has referred to working for temp agencies where he would only work for a short time and he asked to not return. Mr. S. often refers to arguing with others and specifically, he is not welcome to visit his girlfriend because the people she stays with will not allow him to come to their home. When Mr. S. has staying at Safe

Documenting Disability: Simple Strategies for Medical Providers

Haven, he did not get along with the other residents and complained constantly about their behaviors. It was explained to him that all residents have mental health issues, but Mr. S. continued to not get along with and often argue with the other residents. Mr. S. did attend a Health Care for the Homeless sponsored picnic. He sat by himself and when others went and sat by him, he did not talk with them at all. Mr. S. is often uncooperative with this writer, the Therapist, and the Case Manager. He will attend appointments and then yell at the staff. Mr. S.'s strength is that although he discontinued therapy, he does continue to meet with Case Management staff and the Psychiatrist.

Mr. S. has marked difficulties in maintaining concentration. This writer does not have any observance of Mr. S. in a work setting. Ms. Alfredson was able to report that in the setting of case management, they had great difficulty completing the assessment and initial care plan. Mr. S. cannot concentrate on the task at hand and when asked a question, he begins to answer it, but then gets lost on a long tangent. He is difficult to re-direct. The therapist, Mr. Gilman, noted that he could not assess tasks of short-term memory due to tangents and paranoid thinking that the therapist was actually playing a trick on him. I think that Mr. S.'s inability to complete a basic mental status exam is indication that when under the stress of employment, he would not be able to maintain concentration, persistence, or pace.

Mr. S. has also had repeated episodes of decompensation. He was in a decompensated state when first engaged by the Outreach Worker in February 2005. He agreed to treatment by a psychiatrist and after beginning medications, he did demonstrate some improvement. In April 2005, Mr. S. had a Lithium level tested at the lab and the result was slightly below therapeutic level. By May 2005, the Lithium level was within therapeutic level and Mr. S. was reporting to be feeling better. In August 2005, Mr. S. reported to the psychiatrist that he did not take medications for one week and was feeling the effects of mood instability.

In September 2005, Mr. S. again reported to the psychiatrist that he was not taking his medications and his mood was quite irritable. He had also suffered the consequence of getting discharged from the Safe Haven shelter due to non-compliance with rules in September 2005. He continued to report not taking meds and struggling with his moods in October 2005. In November 2005, the consumer reported to be taking his medications again and Case Management was monitoring his medications by only giving him one week at a time. Again, his mood improved, he became more cooperative, and he was granted re-admission to Safe Haven. Also at this time, his psychotropic medication was changed. Mr. S. reported feeling to "up" and agitated from the new medication. By January 2006 he was again asked to leave Safe Haven due to non-compliance with rules. Since that time, he has again been observed to be in a decompensated state. His activities of daily living have diminished, his social functioning markedly impaired, and his concentration again observed to be very low.

In conclusion, it is my opinion that Mr. S. has a severe impairment and meets the criteria listed in section 12.04 of the Social Security Blue Book for Affective Disorder.

Steven Ortell, MD Date

George Gilman, LCSW Date

Jennifer G. Alfredson, APSW Date

Health Care for the Homeless of Milwaukee, Inc.

12.04 Affective disorders: Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one of the following:

1. Depressive syndrome characterized by at least four of the following:

- a. Anhedonia or pervasive loss of interest in almost all activities; or
- b. Appetite disturbance with change in weight; or
- c. Sleep disturbance; or
- d. Psychomotor agitation or retardation; or
- e. Decreased energy; or
- f. Feelings of guilt or worthlessness; or
- g. Difficulty concentrating or thinking; or
- h. Thoughts of suicide; or
- i. Hallucinations, delusions, or paranoid thinking; or

2. Manic syndrome characterized by at least three of the following:

- a. Hyperactivity; or
- b. Pressure of speech; or
- c. Flight of ideas; or
- d. Inflated self-esteem; or
- e. Decreased need for sleep; or
- f. Easy distractibility; or
- g. Involvement in activities that have a high probability of painful consequences which are not recognized; or
- h. Hallucinations, delusions or paranoid thinking; or

3. Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes);

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation, each of extended duration;

OR

C. Medically documented history of a chronic affective disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of decompensation, each of extended duration; or
2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or
3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

*Listing of Impairment specified in the preceding letter
Source: June 2006 SSA Blue Book*

LETTER 3

January 4, 2000

RE: SS# ___/___/___

DOB: ___/___/___

To Whom It May Concern:

I have known Mr. S for the past 15 years, during which time I have cared for this gentleman frequently while working as the Boston Health Care for the Homeless Program's physician at Boston Medical Center, Massachusetts General Hospital, Pine Street Inn Nurses' Clinic, and as a member of the outreach teams serving individuals living on the streets of Boston. His medical and psychiatric issues are very complex, and shadowed in a relatively obscure history (most of his medical charts have either been lost or are unavailable to us).

In my professional opinion, this gentleman is totally disabled and unable to partake in substantial gainful activity. He meets the criteria noted in the Listing of Impairments under both Section **11.08** (Neurology, Spinal Cord and Nerve Root Lesions) and Section **12.02** (Mental, Organic Mental Disorders).

Mr. S's life has been decidedly tragic. He apparently left school in the 8th grade, although the circumstances are unclear. On July 19, 1968, at the age of 17, he sustained severe head trauma with facial fractures, loss of the left eye, and brachial plexus injuries with left arm paralysis and muscle contractions when he was struck by a train. Once again, we have few details about the circumstances surrounding this accident. He apparently was in coma for several weeks, and remained hospitalized for approximately six months. The injuries were substantial and devastating. He sustained severe blunt head trauma that left him with a permanent deformity. His left eye required enucleation, and has been a continual source of purulent drainage and intermittent infections since that time. His brachial plexus was severely compromised, and resulted in paralysis of his left biceps and triceps as well as contraction deformities of the left wrist, PIP, and DIP joints. This brachial plexus injury has also caused considerable vascular compromise, and he has well-documented episodes of recurrent frostbite as well as left hand and arm cellulitis. When last evaluated by the vascular surgeons at Boston Medical Center in December, 1998, the plan was to consider either surgical revision of the arm and vasculature or amputation.

Despite these debilitating injuries, Mr. S apparently attempted to work menial jobs from 1970-1974. He was unable to keep these jobs, although we do not know why. At some point during the rehabilitation from his accident, he began to use alcohol heavily. By 1974, at the age of 23, he became literally homeless and has essentially been living in the shelters or on the streets for the past 25 years.

I have thoroughly reviewed Mr. S's most recent chart at Boston Medical Center, which includes the past two years. He has been seen in the emergency department on at least 45 occasions, generally for grand mal seizures, pancreatitis, frostbite, or cellulitis. The ED visits have a tragic monotony, ending virtually always in his refusal to accept hospital or detox admission and an abrupt departure against medical advice. He rarely remains long enough for diagnostic studies, and I was unable to find documentation of a single EEG during this two-year period (although there are references to "abnormal EEGs in the past"). We have also facilitated multiple admissions to detoxification units for Mr. S through our outreach clinic sites, but he again has rarely been able to tolerate more than 2-3 days in any facility.

It is necessary to sort out his substance abuse issues from his underlying medical problems. While alcohol has been a relapsing and debilitating component of his life in the shelters and on the streets for the past 25 years, his head trauma and the brachial plexus injuries preceded his alcoholism and remain the major reason for his disability:

(1) The severe nerve root and brachial plexus injury have left him with paralysis of the left upper arm and contractions of the musculature of his forearm and hands. The vascular compromise from this injury has resulted in repeated episodes of frostbite and cellulitis, even under conditions of mild exposure with ambient temperatures in the 40s. This significant and persistent disorganization of motor function in the left upper extremity in the setting of his brachial plexus injury meets the primary criteria for disability under Section 11.08 of the Listing of Impairments.

(2) His primary disability is an organic mental disorder, and he meets the criteria listed in Section 12.02 of the Listing of Impairments. His massive head trauma resulted in multiple facial fractures (left orbit, zygoma, maxillary sinus), loss of the left eye, and increased intracranial pressure resulting in prolonged coma and requiring decompression with burr holes. This severe damage to the left frontal lobe is undoubtedly the focus of his seizures and most likely explains his disturbances of mood and his emotional lability with well-documented irritability and explosive outbursts. Alcohol clearly

has lowered his seizure threshold, but cannot explain his entire history of seizures, many of which have come (by his report during several prolonged periods of incarceration) while sober and on Dilantin with adequate serum levels.

Most significantly, a head CT scan in September 1998 showed evidence of old burr holes as well as longstanding encephalomalacia in the left frontal lobe, cerebellar atrophy, and ventricular prominence resulting from volume loss. To be specific, Mr. S easily meets the required level of severity for an organic mental disorder. He demonstrates (A) marked affective changes since his head trauma that predate his use of alcohol and have resulted in mood disturbances and emotional lability that have resulted in (B) marked difficulties in maintaining social functioning (as evidenced by 25 years of homelessness and loss of family and social supports) and repeated episodes of deterioration (as evidenced by his inability to remain in hospital or detoxification facilities).

I hope that this letter has been helpful in assessing this most unfortunate gentleman whose life has been devastated by the head trauma and nerve root injuries he sustained at a young age. In my professional opinion, he is totally disabled. Please feel free to call me anytime with further questions.

Respectfully,

James J. O'Connell, M.D.
 Boston Health Care for the Homeless Program
 Departments of Medicine
 Boston Medical Center and Massachusetts General
 Hospital

11.08 Spinal cord or nerve root lesions, due to any cause with disorganization of motor function as described in 11.04B.

11.04 Central nervous system vascular accident.
 With one of the following more than 3 months post-vascular accident:

B. Significant and persistent disorganization of motor function in two extremities, resulting in sustained disturbance of gross and dexterous movements, or gait and station (see 11.00C).

11.00 Neurological:

C. Persistent disorganization of motor function in the form of paresis or paralysis, tremor or other involuntary movements, ataxia and sensory disturbances (any or all of which may be due to cerebral, cerebellar, brain stem, spinal cord, or peripheral nerve dysfunction) which occur singly or in various combinations, frequently provides the sole or partial basis for decision in cases of neurological impairment. The assessment of impairment depends on the degree of interference with locomotion and/or interference with the use of fingers, hands and arms.

*Listing of Impairment specified in the preceding letter
 Source: 2006 SSA Blue Book*

12.02 Organic mental disorders: Psychological or behavioral abnormalities associated with a dysfunction of the brain. History and physical examination or laboratory tests demonstrate the presence of a specific organic factor judged to be etiologically related to the abnormal mental state and loss of previously acquired functional abilities.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.

A. Demonstration of a loss of specific cognitive abilities or affective changes and the medically documented persistence of at least one of the following:

1. Disorientation to time and place; or
2. Memory impairment, either short-term (inability to learn new information), intermediate, or long-term (inability to remember information that was known sometime in the past); or
3. Perceptual or thinking disturbances (e.g., hallucinations, delusions); or
4. Change in personality; or
5. Disturbance in mood; or
6. Emotional lability (e.g., explosive temper outbursts, sudden crying, etc.) and impairment in impulse control; or
7. Loss of measured intellectual ability of at least 15 I.Q. points from premorbid levels or overall impairment index clearly within the severely impaired range on neuropsychological testing, e.g., Luria-Nebraska, Halstead-Reitan, etc;

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation, each of extended duration;

OR

C. Medically documented history of a chronic organic mental disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of decompensation, each of extended duration; or
2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or
3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

*Listing of Impairment specified in the preceding letter
 Source: 2006 SSA Blue Book*

LETTER 4

May __, 2004
Re: D. A.
SSN: ___-___-____
DOB: __/__/__
MRN: _____

To Whom It May Concern:

I am writing as the primary treating physician of D.A. (DOB __/__/__). I have been treating him since 5/3/02 and seeing him at intervals of 1 week due to the complexity of his medical and mental health conditions. His previous medical care has been received in correctional facilities and at San Francisco General Hospital where he is currently under a court mandated restraining order which prevents him from receiving care there. I have reviewed his extensive past medical records (1993-2002). The following are current active medical problems for this patient:

- 1) Chronic Abdominal Pain: The patient has had multiple abdominal surgeries since childhood. He suffers from chronic pain especially in the left flank and left lower quadrant areas. The pain is constant and unremitting with periodic increases in intensity several times a day. The pain has been attributed to intra-abdominal adhesions which are not amenable to surgical treatment. The pain is also likely related to recurrent kidney stones and extensive past instrumentation of his urinary tract. The patient has a history of left kidney vascular and ureteral malformations which have led to multiple episodes of nephrolithiasis, hydronephrosis, and required multiple surgeries. He has a history of recurrent uric acid kidney stones. He has required high doses of opiate analgesic medication for at least the last 10 years.
- 2) Bilateral Inguinal Hernia: The patient has bilateral inguinal hernias which are awaiting repair. These have been present and causing the patient pain for greater than 1 year. At this time surgical consultation is underway. The hernias are a source of pain and limitation in exertion.
- 3) Degenerative Joint Disease/neuropathic pain: The patient complains of chronic joint pains in his knees and other joints. He has had multiple traumas and accidents and likely has post traumatic arthritis. He also complains of burning/pins and needles type pain in both lower extremities left worse than right. He reports some improvement with gabapentin and indomethacin.
- 4) Asthma and frequent lower respiratory infections: Patient has had 2 episodes of pneumonia in the past 1 year and several episodes in the past and is frequently dyspneic with exertion. He reports some relief with bronchodilatory inhalers.
- 5) Personality Disorder/History of impulsive, violent, and threatening behavior: The patient has a history of multiple traumatic incidents. He has been incarcerated multiple times. His medical treatment has been compromised by the fact that he violently threatened his previous physician who could no longer treat him and obtained a restraining order keeping the patient away from the entire San Francisco General Hospital. The patient feels he has anxiety from traumas which occurred while he was in prison. Professionals who have interacted with him in the past have noted his anti-social behavior and threats of violence. The patient has poor insight into this and feels his behaviors have been misunderstood but it is clear from his history that he has anti-social personality disorder and poses a potential threat in any work or social environment. The patient also has an impulse control disorder and exhibits very poor judgment.
- 6) Substance Abuse: The patient reports previous use of stimulants as his primary problem. He reports previous loss of control of his use of opiate medications. At present he reports he is not using amphetamines, cocaine, heroin, or any other non-prescribed medications. He does not drink alcohol and reports that he is subject to random drug testing as a condition of his parole.
- 7) Hepatitis C Infection: The patient has positive hepatitis C antibody test. Further work up has not been done but his symptoms of fatigue and neuropathy may be attributable to this.

Physical Exam:

Patient appears stated age, somewhat disheveled with poor grooming
HEENT: EOMI, PERRLA, fundi nl. mouth and throat nl, poor dentition with multiple missing teeth and caries
Neck: - adenopathy, - thyromegaly, full ROM

Chest: Exp. wheezes and rhonchi, -rales, - dullness

COR: RRR, S1S2, - murmur, pulses nl.

Abd.: multiple healed surgical scars, diffuse tenderness, - rigidity, - point tenderness, + punch tenderness over left flank, bilat. inguinal hernia reducible with some difficulty and pain

Ext.: +crepittance L knee, full ROM at all joints, - edema

Neuro: alert, oriented x3, CNII-XII nl and symmetrical, strength and sensory nl. and symmetrical

Psych: Patient appears anxious and at times impatient, thought content is predominated by his chronic pain, complex medical history, and anger and frustration that he cannot physically perform his previously normal activities. He is homeless and has minimal social supports, no family support network, no social network. He has not appeared intoxicated or impaired in any encounter. -SI, - HI

Current medical plan: refer patient for surgical repair of bilat hernia, refer patient to comprehensive pain management center (requires Medi-Cal or other medical insurance)

Continue current meds - oxycodone with tylenol 5/325 6/d, indomethacin 25mg 3 bid, gabapentin 300mg 3tid, albuterol inhaler, hydroxyzine 25mg q8hr prn

In Summary:

This unfortunate 40 year old man is currently homeless and socially isolated. His past records and current exam demonstrate long term chronic severe pain. He also has a personality disorder which has caused him to be involved in many violent situations and extensive conflict. In particular this has caused him to be prevented from receiving medical care at the only public hospital in San Francisco. He has a long history of substance abuse but is currently not using drugs. He appears to have some insight into this problem. His ability to respond appropriately to supervisors or co-workers is highly doubtful due to his personality disorder and the poor prognosis for improvement of these types of conditions. It has been felt that his potential to actually commit violent acts is high. Due to chronic pain his concentration and persistence in tasks are very poor. Mr. A's arthritis and lung disease would prevent him from performing a job which required the ability to stand or walk more than two hour in a work day or to lift more than 15 pounds occasionally. If Mr. A follows through with all medical plans he may achieve some general improvement in his functional level but I do not anticipate that even with the maximum expected improvement and continuing abstinence from drugs that he will ever be able to work again. I have attached copies of my relevant treatment records.

Barry Zevin MD
Internal Medicine
Medical Director, Homeless and Community Services
Tom Waddell Health Center

LETTER 5

May 12, 2004

Re: E. A.

SSN: ___-___-_____

DOB: __/__/__

MRN: _____

Social Security Analyst:

Mr. _____ of the Disability Evaluation Assistance Program referred Mr. E. A. for a medical consultative examination. He was evaluated today in collaboration with Dr. Barry Zevin. Medical records from San Francisco General Hospital and South East Health Center were also used for this report.

Mr. A. was raised in San Francisco. He was a junior high and high school athlete, primarily running track, and playing football and basketball. He left high school in the 12th grade to join the job corps and never finished his GED. He states he is quite illiterate. He can read some words and a few sentences in the newspaper, and has trouble spelling. He does not write very well. After high school he worked in a car wash for approximately 10 years and later became a security guard. He only did security for about 6 months when he was forced to quit due to severe knee pain. He worked off and on, the last job was sweeping the streets for SLUG, which he enjoyed but was only able to do for 6 months, again leaving due to too much missed work from the knee pain and progressive hip pain. His last day of work was 9/11/01.

He now complains of bilateral knee pain, bilateral hip avascular necrosis, benign prostatic hypertrophy and some recurrent "distress", with some depression in the last year. His wife of 23 years passed away 1 year ago and he is having great difficulty adjusting. He has 3 grown children whom he sees only occasionally. He is currently on GA and is living with his grandmother. He states his greatest problem is the constant, throbbing and shooting pain he experiences. He complains of great difficulty using public transportation. He can not get on the "kneeling bus" without using both hands and arms to pull him up the stairs. He states he is unable to carry groceries and cannot sweep or vacuum. He is able to stand for short periods of time to do dishes.

Medical Problems:

Bilateral hip pain

He describes severe aching and shooting pain in his left hip for the last 3-4 years. He was sent to the orthopedic clinic at SFGH. They performed a left hip core decompression for avascular necrosis on 7/25/03. He continues to have constant pain, 8/10 on a pain scale of 1-10, 10 being the worst possible pain. He is being treated with Tylenol with Codiene #3, two every 4-6 hours without relief. He describes the pain as shooting down the side of his leg, sometimes accompanied by a warm sensation of hot oil going down the front. MRI dated 4/22, 2004 shows core decompression of the left hip with granulation and continued avascular necrosis (AVN). The right is without AVN of the trochanteric head but does show inter-trochanteric necrosis. These conditions are consistent with the amount of pain he is experiencing. Due to a GI bleed he is unable to take NSAID's.

Knees

He complains of recurrent, worsening bilateral knee pain. He remembers being told that he needed "knee cap replacement" with a plastic patella. He was afraid of the surgery and did not pursue it. He was diagnosed with patellofemoral syndrome on the left, after the core decompression of his hip. Plain films from January 8, 2004 show bilateral infarcts of the distal diaphysis of the right and left femur and a bony infarct involving the posteromedial left tibia.

Left arm radiculopathy

He has left arm numbness and a deep ache. The pain is intermittent and often disturbs his sleep. An MRI is scheduled for July 12, 2004 to further evaluate the cause of the radiculopathy.

Low Back Pain

MRI of the lumbar spine dated 4/22/04 showed broad based disk bulges of L3-4, L4-5 and L5-S1. There appears to be mild canal stenosis and the bulges may be touching the L5 and S1 nerve routes.

Substance Use

He describes using drugs and alcohol since the age of 13. He became clean and sober 5 years ago and remains so today. He describes the last year being difficult since his wife's death but he is proud of himself for not using drugs.

Benign Prostatic Hypertrophy

He has a history of urinary dripping and frequency, which is being followed by a Urologist. He is taking Terazosin 10 mg daily with moderate relief.

Findings:

General: Mr. A arrived on time for his appointment. He was clean and well dressed and walked with a cane and a significant broad based limp. He was unable to do the heel to toe walk or walk on his heels and toes without holding on to the walls. He was pleasant and articulate however he had a depressed affect. He seemed somewhat distressed in his speech. He squirmed frequently in his chair and had very frequent spasmodic jerking. He attempted all requested maneuvers with moderate difficulty in carrying them out.

Height: 70", Weight: 164 lbs., B/P sitting (R): 140/82, Pulse: 72

HEENT: Unremarkable

Spine: Tender midline at the lumbosacral area. Decreased range of motion with lateral bending bilaterally, limited by pain and loss of flexibility. He did have positive straight leg raises on the right while supine.

Upper Extremities: Full ROM and strength equal bilaterally.

Cor: Bounding without murmur. Skin is warm and dry.

Pulm: Clear to auscultation, all lobes.

Abd: Liver tender, not enlarged

Lower Extremities: Both knees were painful with flexion. Able to perform a ~ 30° deep knee bend. Crepitus present bilaterally on passive and active range of motion. He had significant hip pain with flexion limited to ~80°/ 110° on the left. There was significant loss of internal and external rotation of the left hip. The right hip was painful with all maneuvers, with moderate generalized limited range of motion.

Neuro:

DTR's	Biceps	Triceps	Patellar	Achilles
Right	I+	I+	I+	0
Left	I+	I+	I+	0

Summary

Mr. A is a pleasant 52 year old man. He suffers from significant deep-seated pain in both of his hips and knees as a result of many different disease processes. The progressive nature of the avascular necrosis, intertrochanteric necrosis and bony infarcts in all weight bearing joints, has become almost totally debilitating. Given his long and active athletic and work history, it is evident that he would work if he possibly could. He has made many attempts to maintain work only to have to quit due to the pain and lack of physical endurance. He is still in the process of a workup for his upper extremity radiculopathy.

Observation of him and his physical state during the interview and exam showed him to be in severe discomfort with sitting for even a short period of time. His grimacing and spasmodic jerking from pain were very distracting and obviously debilitating. His broad based gait and limp, assisted by a cane was slow and labored. His depressed / distressed affect could certainly be from the severity of his chronic pain.

I do not believe that Mr. A can sit or stand for more than 15 minutes without the opportunity to alternate position. He cannot walk without the use of a cane. While he holds his cane in his dominant right hand, his use of the left arm/hand is severely restricted by radiculopathy. Although he can use his right hand to lift when in the seated position, he cannot carry even 10 pound weights. He has chronic pain while on a high dose of narcotic medication. His ability to concentrate is severely impaired. His past history of substance use is not material to his case.

If he were to be awarded disability benefits, I believe he would be able to manage his own funds without difficulty. I have enclosed copies of my relevant treatment records.

Sincerely yours,

Masa Rambo, RN, MS, FNP
 Barry Zevin, MD
 Diplomate, American Board of Internal Medicine

CITY AND COUNTY OF SAN FRANCISCO



Department of Public Health
Homeless Programs
Tom Waddell Health Center

50 Lech Walesa Street
San Francisco, CA 94102
Telephone: (415) 355-7400
FAX: (415) 355-7407

LETTER 6

Medical Summary [10/04] S.L.

I have followed S. L. as his primary care treating physician since 8/15/03. I have seen him approx. every 6 weeks since that time and at times more frequently. Mr. L. is a 54 year old man who initially presented with a history of mental health problems, alcohol abuse, and a history of back problems and hospitalization for "pneumonia and congestive heart failure." On presentation he was homeless and sleeping on the steps of a church. He was unable to access services due to severe anxiety and shame. He reported a career as a ballet dancer and choreographer both in the United States and Europe. He is currently abstinent from alcohol and seeking psychiatric treatment. His problems and course in summary:

Bipolar disorder: the patient was diagnosed with bipolar disorder in New York City several years ago. He reports greater than 20 years of episodic severe depression, alternating with periods of feeling invincible and starting big projects. Symptoms of his disorder include anxiety with severe panic attacks, many losses including failed relationships, lost friendships, homelessness, and severe interference with his career. He reports bulimia and anorexia as symptoms he has struggled with for many years. He reports episodes of using alcohol to blunt his feelings of irritability, depression, and anxiety. Previous treatment had included Valium and ativan. He reports being told that he might need medications to stabilize his mood but never took these nor believed he needed them. Initial attempts at prescribing Valproate (Depakote) to him were unsuccessful due to his perception of side effects. He was referred to a psychiatrist (Dr. Hammond) and psychotherapist at Mission Mental Health Center. He was prescribed anti-psychotic medication but did not adhere well to this. Most recently he has been restarted on Valproate which he has tolerated since he has been abstaining from alcohol. His poor insight and the presence of a co-occurring narcissistic personality style or disorder have complicated his psychiatric care.

Musculoskeletal complaints: the patient reports a history of problems with his back, extremities, and "diaphragm" which result from his years as a dancer. He has received various therapies in the past for these and reports he can no longer dance professionally due to his pain but otherwise copes with his chronic pain. He has not requested further work up or treatment of his pain.

CHF/pneumonia/: these were apparently acute and resolved problems. There are currently no signs of heart or lung problems.

Alcoholism: The patient has a history of drinking in an excessive and uncontrollable manner. He has required several episodes of medically supported detoxification while under my care. He participated in a residential rehab program at Baker Places and was abstinent for 3 months but continued to have severe psychiatric symptoms and relapsed soon after completing the program. He required hospitalization in July 2004 after being assaulted when intoxicated. He had severe alcohol withdrawal at that time and required medical detox. He had a seizure which we have assessed as alcohol related at that time. He has abstained from alcohol since that time and reports he has had 13 years of sobriety between 1989 and 2002 and feels he has the tools to do this again especially if his underlying psychiatric issues are stabilized.

Multiple somatic complaints: The patient has had frequent complaints of respiratory, GI, and GU complaints. These do not seem to be caused by any underlying severe disorder but reflect somatization of his underlying psychiatric disorders.

In Summary: S. L. has a long history of untreated Bipolar disorder and alcoholism. Observation of him during periods of abstinence strongly suggests that his psychiatric disorder is the primary diagnosis. He has been unable to engage in any Substantial Gainful Activity during the period of time I have been treating him. At times he has embarked on volunteer work or started planning for large projects but has been unable to follow through with these commitments. His insight into the nature of his problems is low. With continued treatment he has a guarded chance of recovery and improvement but I would expect this to require several years of adherence with medications, psychotherapy, and abstinence from alcohol. If Mr. L. were to be awarded benefits I would recommend that he have a payee for money management as his illness has a severe effect on his judgment.

Barry Zevin MD
Diplomate American Board of Internal Medicine

CITY AND COUNTY OF SAN FRANCISCO


 Department of Public Health
 Homeless Programs
 Tom Waddell Health Center

 50 Lech Walesa Street
 San Francisco, CA 94102
 Telephone: (415) 355-7400
 FAX: (415) 355-7407

LETTER 7

Medical Summary Update 2/9/06 S.L.

This is a follow up to a letter written in 10/04. I have continued to follow this patient as his primary care treating physician. I have seen him at intervals of about monthly and at times weekly. Unfortunately the patient's condition has deteriorated since that time. He has attempted paid or volunteer work a few times in the past year but these have ended quickly due to his inability to maintain psychiatric stability. This will update the patient's problems as outlined in the previous letter:

Bipolar disorder / narcissistic personality disorder: The patient has now been taking Divalproex sodium (Depakote) on a regular basis. He has had good adherence and reports the medication helps avoid what he describes as his manic episodes. He still has episodes of severe depression which have triggered relapses to drinking alcohol several times over the past 4 months. He has had less episodes of panic attacks in the past year but continues with occasional (about once a month) very debilitating panic and daily anxiety effecting his ability to function. He has had several referrals and episodes of treatment in the mental health system since the last report. Each of these has ended with patient dissatisfaction and exacerbations of the patient's condition. He has also had conflict and increased stress related to his attempts to return to working as a ballet instructor. He was apparently accused of some type of inappropriate behavior toward a young student. These conflicts and difficulties are consistent with his diagnosis of narcissistic personality disorder. Unfortunately no psychotherapy has been effective as of yet in helping the patient cope with this problem. In the past 6 weeks the patient has had at least 6 emergency room visits due to feelings of severe depression, anxiety, and suicidal behavior or ideations. The patient is socially very isolated at this time and is markedly impaired in this area. He is having a very difficult time keeping up with basic self care. He has markedly impaired concentration, persistence, and pace.

Musculoskeletal complaints: The patient continues with complaints of back and joint pain. These seem to be degenerative in nature. They limit him from exercising as he would like to and would likely limit his ability to do exertional work. He has not requested treatment or further diagnostic studies for these problems.

Alcoholism: The patient maintained sobriety for greater than 1 year during 2004-2005. He reported no or low amounts of craving except during periods of increased anxiety and depression. In the past 3-4 months he has had several drinking episodes (binges). These have resulted in his depression and anxiety getting worse. We treated his alcoholism with extensive counseling and also tried naltrexone. He does not seem to tolerate the medication well and as of yet he does not seem to be having much benefit. He had one episode in residential medically supported detox. He left before completing the full course of treatment (3 weeks) again related to his narcissistic personality disorder. The relationship of his mental illness to his alcoholism continues to be very strong. His mental health symptoms do not abate during periods of sobriety. These symptoms do become more dangerous when he is drinking as he becomes more impulsive and potentially acts on his suicidal ideations.

In summary: The patient's condition has somewhat deteriorated over the past year. The patient meets listings in section 12.04 and 12.08 in the Disability Evaluation Under Social Security. The patient does have a diagnosis of alcoholism and this is of serious concern as outlined above. Observation of the patient during extended periods of sobriety and based on past history indicate that the patient's impairments exist independent of the patient's alcoholism and alcoholism is not material to the patients disability. Please feel free to contact me if I can be of any further assistance.

Barry Zevin MD
 Diplomate American Board of Internal Medicine
 Certified in Addiction Medicine
 American Society of Addiction Medicine

CITY AND COUNTY OF SAN FRANCISCO



Department of Public Health
Homeless Programs
Tom Waddell Health Center

50 Lech Walesa Street
San Francisco, CA 94102
Telephone: (415) 355-7400
FAX: (415) 355-7407

LETTER 8

Medical Summary 2/9/06 V. H.

I have followed V. H. as his primary care treating physician since 8/6/04. I have seen him at intervals of 1 month or more frequently. The patient presented for care with complaints of back pain, pain from inguinal hernia, history of bipolar disorder, and homelessness. The patient perceived himself as quite ill but also expressed the expectation that he would soon be able to return to work. The patient has been an extremely high user of medical services due to physical illness and mental illness. Since 7/04 the patient has had 166 encounters in our health network alone (San Francisco General Hospital and Tom Waddell Health Center). He has had numerous visits at other hospitals and crisis centers which I do not have records of but have been reported by the patient. He has had conflict with staff and has appeared to be threatening and possibly violent at times. Education and redirection toward more appropriate and healthier uses of the healthcare system have not been effective. This likely reflects the seriousness of his mental health disorders. The patient's medical problems include:

Chronic Back Pain: The patient complains of severe and intractable pain in his lower back. He reports onset of this pain after an injury in 2000 in which he reports "disc rupture of L4 and L5." Medical records from that time are not available to me. Lumbar spine X-Ray shows rotatory levoscoliosis, osteophytes at the level of L4 through L5, narrowed disc space with vacuum phenomenon seen at the level L5-S1. This is consistent with the patient's history and subjective complaints. He has been treated with NSAIDs which have not been effective. The patient is treated with MS Contin (extended release oral morphine) which has been partially effective for the patient's pain. He has had constipation and some sedation as a side effect. With use of the morphine he is able to sleep more comfortably and ambulate. He still has severe pain with bending or lifting any weight. He is not interested in considering surgical options and has been too unstable to follow up for physical therapy.

Inguinal hernia recurrent: The patient has had R and L inguinal hernias and has had at least 3 surgeries in the past year. His post-operative self care has been poor due to his homeless status and poor judgment. He does have pain in both inguinal areas. His ability to stand long periods or walk for extended periods is effected by this pain.

Asthma/COPD/bronchospasm: the patient has an extensive smoking history. He is short of breath at times and this is so severe that he must go to the hospital emergency department several times each year. CXR shows increased lung volumes suggestive of COPD. Office spirometry was within predicted range with small improvement after inhaled bronchodilator. The patient uses albuterol and atrovent and steroid inhalers regularly. He may have periodic exacerbations of asthma. His pulmonary symptoms may also be exaggerated by his mental health disorders. Smoking cessation counseling is underway and full PFT's would be beneficial.

Bipolar Disorder: The patient reports bipolar disorder initially diagnosed in 1990. He also reports he was "hyper" as a child but it is unclear if this was ever diagnosed or treated. The patient reports a family history that his mother had manic depression and committed suicide in 1988. The patient reports his symptoms as episodes of severe depression and episodes of acting impulsively and with very poor judgment. He reports he did well when prescribed Lithium between 1990 and 1999. He reports stopping because he thought he was better. He has had many losses and problems since that time including loss of his home and jobs. The patient has received treatment at Westside Crisis Clinic and South of Market Mental Health Clinic. He was initially prescribed several medications and reports adherence to them. He has been non-adherent with appointments and follow up and has not been on medications regularly for approximately the past year. At times he has acted in an impulsive manner here in the clinic and staff have felt threatened and that he was capable of being violent. He has not been physically violent in the clinic but has been asked to leave at times.

At times the patient has appeared quite depressed in the clinic. He is often quite irritable and describes episodes that he can not name as irritability but are quite typical of bipolar disorder. He has exhibited grandiosity at times. He has kept most of his appointments and been late at times. His hygiene and self care has ranged from adequate to poor. He has not been able to obtain or maintain housing and usually uses homeless shelters. He expresses high levels of guilt and shame about his condition at times and minimizes and denies his problems at other times. He appears to have few or no friends and no social support system. The patient has marked impairments in his concentration, persistence and pace. In the time

I have been seeing him his condition has somewhat worsened. We continue to redirect him and move him toward obtaining mental health care. He seems overall hopeless that he will be able to benefit at this point from such care.

Substance Abuse: The patient initially reported occasional alcohol use and later noted “recreational” cocaine use. He reported that he felt these were not a problem for him. Further evaluation over time indicates the patient does have a substantial problem with stimulant abuse of crack cocaine. He does not appear to drink alcohol regularly and does not appear to abuse opiates or other sedatives. He has never reported to the clinic in an intoxicated state. He has received very extensive counseling from myself and our staff and been offered assistance. The patient appears to have some insight and acceptance of this as a problem which represents progress from his initial presentation. He has not moved toward obtaining treatment and we continue to use motivational enhancement techniques. The patient’s cocaine use clearly exacerbates his underlying medical and psychiatric conditions.

Somatization and extensive use of medical system: The patient has had numerous complaints of pain and numerous other symptoms for which he has presented to emergency rooms and urgent care centers. He does not appear to have severe physical problems causing these symptoms but they appear to represent a high degree of anxiety and somatization. Review of these records demonstrates that the patient has not been making these visits as “drug seeking behavior.” He reports to the medical staff that he is receiving opiate medication from his primary care physician and does not ask for additional medicine. The visits appear to be impulsive behavior and help seeking. Efforts to redirect this help seeking to more productive ends have failed thus far but will continue.

Summary

Mr. H. is an unfortunate 48 year old man with physical and mental health problems. He has severe back pain requiring opiate analgesic treatment. It is likely that the extent of this back pain would prevent him from doing any activities that required more than minimal exertion. He has bipolar disorder which manifests as depression at times and irritability and impulsiveness. He has exhibited very poor judgment. He has had multiple losses and been unable to function adequately to obtain his own housing. He uses crack cocaine which exacerbates his condition. I do not believe the patient has had any extended period clean from drugs during my care of him to evaluate the severity of his impairments without drugs. His health seeking behavior is disordered in a way atypical for patients primarily with stimulant dependence as their diagnosis. His symptoms and behavior are more typical of Bipolar disorder and probably a personality disorder than stimulant abuse alone.

As a physician with extensive experience in addiction medicine it is my best judgment that this patient would have severe impairments even if he were abstinent. The patient’s prognosis for improvement is guarded. His back pain is likely to continue or worsen as he ages. His mental health disorders while treatable are not curable. Poor judgment about the need for adherence to medication is particularly common in bipolar disorder. This patient’s impairments taken together meet or equal listings in Disability Evaluation Under Social Security. I believe this is the case independent of the patient’s substance abuse. If this patient were awarded benefits I would recommend that he have a mandated payee due to his poor judgment and likely inability to provide minimal food, clothing, and housing for himself.

Please feel free to contact me if I can provide any further information.

Barry Zevin MD
Diplomate American Board of Internal Medicine
Certified in Addiction Medicine
American Society of Addiction Medicine

LETTER 9

Ms. Jane Jones or Ms. Francine Smith
Disability Determination Services
P. O. Box 6338
Timonium MD 21094-6338

Re: A.P.
DOB:
SSN:

Dear Ms. Jones or Ms. Smith:

Ms. A. P. is a 25-year-old, married, Caucasian female who was first hospitalized psychiatrically in August, 1997 and who has had several hospitalizations and day hospital stays since that time. Ms. P. is a soft-spoken, anxious, tall woman of average build. She wears glasses. She is struggling enormously with her illness of schizoaffective disorder and desperately wants, as she states, to be “normal.” She is cooperative with treatment but is easily stressed and, when this happens, she often becomes symptomatic. She needs a great deal of support to maintain herself in the community.

...

Functional Information

According to Ms. P., a typical day is one in which she gets up at about 8 a.m. and showers. She sometimes eats breakfast. She said that her family assists with cleaning the house. She does clean the cats’ litter boxes and feeds the animals (4 cats and one dog). When she was attending the ADH, her mother-in-law would transport her. She generally watches television during the day. Her husband generally arrives home from work between 4:30-5:00. Her family supplies dinner for Ms. P. and her husband. She goes to bed between 10-10:30 p.m.

Ms. P. experiences significant impairment in her activities of daily living, in her social functioning, and in her ability to complete tasks. She has been unable to work since her release from the Army in 9/97.

Regarding her activities of daily living, in her interview with the SSI Project Director, Ms. P. said that her mother-in-law or her grandmother cooks for her; she said that she doesn’t know how to cook. Earlier in her illness, she had great difficulty talking on the phone and would experience “bad anxiety attacks. I couldn’t sit still enough to use the phone.” She does better with this now. To obtain a phone number, she said that she would call another friend who might have it or would use the yellow pages. Her family, especially her mother-in-law, takes care of her food shopping. She said that she went with her mother-in-law once but became very anxious. At the end of May, Ms. P. still spoke of her struggle with completing housework. She said that her mother-in-law and her husband do most of the household chores. Ms. P.’s grooming and hygiene are usually good except when she is symptomatic. She is able to handle her own finances. She has never been to the post office. Generally, her family or friends provide transportation for her to her appointments or on other outings.

Socially, Ms. P. is much more inhibited than she used to be. She generally stays inside watching television and said she “prefer[s] it.” She said that she becomes “a little uneasy” around “big crowds” and feels as though “people around me can tell I have an illness.” She becomes anxious if there are several people in her house. She said that her heart races and she takes “big gulps of air.” She said that she feels that she handles anger well, by expressing it verbally. Prior to her illness, she said, she was “outgoing.” This is no longer true. She participated in groups at the ADH but prefers individual time with others and in treatment.

Ms. P. often has difficulty persisting and pacing herself in the completion of tasks. She said that she finds it “really hard” to concentrate, but this has improved somewhat since her illness began. She finds that she “lose[s] her train of thought” easily, and this bothers her. She also finds that she has difficulty remembering “things that happened before I got ill.” When giving her history to the SSI Project Director, she had difficulty remembering dates. She said that she used to have a “drawing hobby,” but that she cannot do this anymore. She also enjoyed reading but finds this difficult because of problems with concentration and focus.

Ms. P. has not been employed since she was discharged from the Army in 9/97. Recently, she has been talking about working part-time but has not done so or attempted to do so.

Summary

Ms. P. is a 25-year-old, married woman who was first hospitalized approximately a week after she entered the Army, in August, 1997. Between August and December, 1997, she was hospitalized six times and had three episodes of treatment in a day hospital. Currently, she is involved with an intensive outpatient mental health team that provides treatment and case management services. She meets with her therapist twice a week. With this intensive support, Ms. P. has been able to remain out of the hospital. She is easily stressed, becomes anxious and, less often, experiences a recurrence of psychotic symptoms. She worries a great deal about managing her illness and getting back to “normal.” In addition, she feels stressed in her marital relationship and worries about the finances. Currently, Ms. P. is waiting for placement in a psychiatric rehabilitation day program. This would assist her in providing some structure to her day as, right now, she spends most of the day alone, watching television.

Ms. P.’s illness has been severe and disabling, and she is unable to work.

If you have any questions, please contact Ms. Perret at 410-328-1406 or Dr. Billingsley at 410-555-5555.

Sincerely,

Yvonne M. Perret, LCSW-C
Project Director

John Billingsley, M.D.
Psychiatrist

LETTER 10

May 1, 2001
Ms. Freida Johnson
Disability Determination Services
P.O.Box 7373
Fair Chance, MD 21643-7373

Re: L. W.
DOB:
SSN:

Dear Ms. Johnson:

Mr. L. W. is a 26-year-old, single, African-American male who has a history of psychiatric hospitalization dating back to 1992. Mr. W. is a tall (6'1") man of slim build. He has cognitive limitations; for example, he could not find his way back to the SSI Project office even though he had been there twice before. He has difficulty keeping appointments and needed a great deal of outreach to maintain contact and to stay in treatment. He is a poor historian and is quite vague. He appears to be attempting to provide information, but his recall is poor.

When first interviewed by the SSI Project Director, Mr. W. presented with a strong body odor. He was ill-kempt. His speech was rambling and frequently non-responsive to the question. When asked about his mother, he began to cry. He spoke over and over about "not being able to go on" this way. He could not guarantee that he would be able to keep himself safe. Therefore, the Project Director walked him over to Babylon Psychiatric Crisis Center for evaluation. From there, he was admitted psychiatrically.

...

Functional Information

In general, Mr. W. said, most of the time he is up and walking around. He sometimes stays at a mission, sometimes at relatives, and sometimes on the street. For a short period of time, he was living at the Safe Haven, a transitional housing program. Typically, he usually misses breakfast and sometimes eats lunch at the soup kitchens, mostly at Our Daily Bread. He is out most of the day. Mr. W. tends to present his functional ability as more capable than observations note.

Functionally, Mr. W. exhibits significant impairment in most areas. He states that he can cook and names rice and frozen patties as things that he can cook. He is able to use the telephone and could look up a phone number in the yellow pages. He said that he doesn't eat much and would likely need help shopping for food and other items. He believes that he can keep things clean. However, he has never had his own place to live and his appearance is not clean. Although he states that he makes sure he's clean, he had a strong body odor on several occasions when seen by the SSI Project staff, and his clothes are often quite dirty. He is unkempt as well. He said that he obtains clothing from the shelters. He describes his psychiatric symptoms in terms of "stress," which affects his ability to take care of his personal needs. He needs a representative payee to handle his presumptive SSI benefits and does not manage money well at all independently. Although he states that he can ride the bus, he does so only on routes that he knows and has difficulty finding new places. As was mentioned, he has been homeless for some time and has never maintained his own independent housing but rather has relied on family and shelters to house him.

Socially, Mr. W. has troubled relationships and has no friends. His relationship with his mother is conflicted as is his relationship with his sister. He notes himself that he has no "long-term" friends. When angered, he claims that he will face the problem and tell others what he didn't like. However, as recently as last year, he faced an assault charge for hitting his brother in anger. He frequently experiences psychotic symptoms that contribute to very difficult interactions with others. His representation of managing his behavior is not accurate.

Frequently, Mr. W. does not answer the question asked of him, i.e., his response is not appropriate for the question. For example, when asked about his concentration, he said it was "very good" and used as an example the following: "I was up on Pennsylvania Ave. A guy came upon me. I said please don't do anything to me. I was real scared. I begged him so he left. I believe in honesty." His memory is grossly intact but he has difficulty reporting dates and is vague about his history. He said that he likes "conversating" with others, but his conversation is frequently difficult to follow.

Mr. W. has been unable to sustain any employment for a significant period of time. His primary work history consists of temporary agency placements, and these were generally brief.

Summary

Mr. L. W. is a 26-year-old single male who has a history of psychiatric hospitalization dating back to 1992. Early on in his psychiatric treatment history, he was diagnosed with neuroleptic malignancy syndrome, thus making subsequent treatment difficult. In addition, in the last few years, he has begun abusing marijuana and cocaine, stating that the cocaine helps take the “stress off my mind.” Mr. W. has been intermittently homeless for a long period of time. His homelessness, poor interpersonal skills, use of cocaine and marijuana to treat his symptoms, and his dependence on his family have made any semblance of effective independent functioning impossible. He has maintained no steady relationships nor stable living. He has had a lengthy history of psychotic symptoms, violent acting out, lack of compliance with consistent outpatient treatment, and poor management of his life. Mr. W. clearly has schizophrenia. His family has tried to assist him, but they have found him to be very difficult to have in their homes given his assaultive and psychotic behavior. At the present time, Mr. W. is receiving services from the UMMS PACT team, an intensive, mobile outreach team for adults with serious and persistent mental illness. This team is reserved for individuals who have been non-responsive to conventional treatment.

Mr. W. has very limited employment history. He is clearly disabled and unable to work.

If you have any questions, please call Ms. Rothschild at 410-328-1406 or Dr. Brown at 410-328-2564.

Sincerely,

Maria M. Rothschild, LCSW-C
Program Director

Francis Brown, M.D.
Psychiatrist, PACT

REFERENCES

- Baumohl J, Speiglmann R, Swartz JA, & Stahl R. (2003). Substance abuse and welfare policy at the new century. *Contemporary Drug Problems*, 30(1-2): 501-537.
- Bazon Center for Mental Health Law. *Arrested? What Happens to Your Benefits If You Go to Jail or Prison? A Guide to Federal Rules on SSI, SSDI, Medicaid, Medicare and Veterans Benefits for Adults with Disabilities*. <http://www.bazon.org/issues/criminalization/publications/arrested/index.html> [accessed 8/8/07]
- Bonin E, Brehove T, Kline S, Misgen M, Post P, Strehlow AJ, Yungman J. *Adapting Your Practice: General Recommendations for the Care of Homeless Patients*. Nashville (TN): Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc.; 2004; 44 p.: <http://www.nhchc.org/Publications/6.1.04GenHomelessRecsFINAL.pdf>
- Bureau of Primary Health Care. PAL 2001-27: Information Regarding New Guidance on the Health Insurance Portability and Accountability Act Privacy Rule, September 18, 2001: <ftp://ftp.hrsa.gov/bphc/docs/2001pals/2001-27.txt>
- Burt MR, Aron LY, Douglas T, Valente J, Lee E, Iwen B. (1999). *Homelessness: Programs and the People They Serve: Summary Report – Findings of the National Survey of Homeless Assistance Providers and Clients*, HUD Technical Report. Washington, DC: The Urban Institute. http://www.huduser.org/Publications/pdf/home_tech/tchap-05.pdf
- Burt M and Sharkey P. (June 2002). The Role of Medicaid in Improving Access to Care for Homeless People. Kaiser Family Foundation: 37-58. http://www.urban.org/uploadedPDF/410595_AccessToCare.pdf
- Center for Substance Abuse Treatment (CSAT). (Fall 2006). Identifying and Helping Patients with Co-Occurring Substance Use and Mental Disorders: A Guide for Primary Care Providers. *Substance Abuse in Brief Fact Sheet*, 4(2). http://kap.samhsa.gov/products/brochures/pdfs/saib_0402.pdf
- Culhane D, Metraux S, and Hadley T. (2002). Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing. *Housing Policy Debate*, 13(1): 107-163. http://www.fanniemaefoundation.org/programs/hpd/pdf/hpd_1301_culhane.pdf
- Dalton M. (June 2006). Social Security Policy on Drug Addiction and Alcoholism: Changing times...Changing Attitudes? Presentation, HCH Policy Symposium. <http://www.nhchc.org/>
- Dennis D, Perret Y, and Seaman A. (2007). *Expediting Access to SSA Disability Benefits: Promising Practices for People Who Are Homeless*. Delmar, NY: Policy Research Associates, Inc. <http://www.prainc.com/SOAR/tools/pdfs/PromisingPractices.pdf>
- Frisman LK and Rosenheck R. (May 2002). The impact of disability payments on persons with addictive disorders. *Psychiatric Annals, Psychology Module*; 32(5): 303.

HCH Clinicians' Network (CN). *Healing Hands* articles:

- Addiction on the Streets: Clinical Interventions. (October 2006).
<http://www.nhchc.org/Network/HealingHands/2006/Oct2006HealingHands.pdf>
- Closing the Door to Homelessness: How Clinicians Can Help. (November 2005).
<http://www.nhchc.org/Network/HealingHands/2005/Nov2005HealingHands.pdf>
- Dealing with Disability: Cognitive Impairments & Homelessness. (Mar 2003).
<http://www.nhchc.org/Network/HealingHands/2003/hh-0303.pdf>
- Homelessness & Family Trauma: The Case for Early Intervention. (May 2003).
<http://www.nhchc.org/Network/HealingHands/2003/hh-0503.pdf>
- Dealing with Disability: Physical Impairments & Homelessness. (Oct 2002).
http://www.nhchc.org/Network/HealingHands/2002/hh.10_02.pdf
- Mental Illness, Chronic Homelessness: An American Disgrace. (Oct. 2000).
<http://www.nhchc.org/Network/HealingHands/2000/October2000HealingHands.pdf>
- Trauma and Homelessness. (Apr 1999).
http://www.nhchc.org/Network/HealingHands/1999/hh.04_99.pdf
- Bridging the Gap: What We Know and Don't Know about Dual Diagnosis. (Jul 1998).
<http://www.nhchc.org/Network/HealingHands/1998/Jul98HH.pdf>
- Hunt SR and Baumohl J. (March 22, 2003). Drink, drugs and disability: an introduction to the controversy. (Social Security Administration's drug addiction and alcoholism program); *Contemporary Drug Problems*; 30(1). http://www.accessmylibrary.com/coms2/summary_0286-12058724_ITM
- Kraybill K and Zerger S. (2003) *Providing Treatment for Homeless People with Substance Use Disorders: Case Studies of Six Programs*. National Health Care for the Homeless Council.
<http://www.nhchc.org/Advocacy/FactSheets/CA05RCASESTUDIES-FINAL5.pdf>
- Landry L; Disability Law Center, Boston, MA. DAA Issues Update (June 2006); *Disability Benefits Project SSI Coalition Newsletter*; XXV(3), May - July, 2006, 92-100. Accessed 9/11/06 at:
http://www.masslegalservices.org/page/231532;cat_id=258
- Leo RJ and Del Regno P. Social Security claims of psychiatric disability: Elements of case adjudication and the role of primary care physicians. (2001). *Primary Care Companion J Clin Psychiatry* 2001;3(6). <http://www.psychiatrist.com/pcc/pccpdf/v03n06/v03n0608.pdf> [accessed 8/7/07]
- McIntyre G. Have you seen a fleeing felon? Social Security Administration targets SSI recipients with outstanding warrants. (Jan-Feb 2003). National Senior Citizens Law Center.
http://www.lanecountylegalservices.org/Have_you_seen_a_fleeing_felon.pdf [accessed 8/8/07]
- McKee P. An Advocate's In-Depth Guide to Social Security Disability and Medical Letter Guide. Douglas, Drachler & McKee, LLP, 1904 3rd Ave., Ste 1030, Seattle, WA 98101; TPHDM@Qwest.net
- National Senior Citizens Law Center. "Fugitive Felon" Penalty. http://www.nslc.org/areas/social-security-ssi/area_folder.2006-09-26.2745496389 [accessed 8/8/07]
- National Alliance on Mental Illness (NAMI). Dual Diagnosis and Integrated Treatment of Mental Illness and Substance Abuse Disorder. <http://www.nami.org/> [accessed 8/8/07]

Documenting Disability: Simple Strategies for Medical Providers

- National Institute on Drug Abuse (NIDA). Diagnosis & Treatment of Drug Abuse in Family Practice. <http://www.nida.nih.gov/Diagnosis-Treatment/diagnosis3.html> [accessed 8/8/07]
- National Health Care for the Homeless Council; National Law Center on Homelessness & Poverty. *The Effects of SSI & SSD Benefits Termination as Seen in Health Care for the Homeless Projects*, April 1999: <http://www.nhchc.org/Publications/ssi.html>
- National Law Center on Homelessness & Poverty. *Advocating on Behalf of SSI Claimants: A Guide to Rights & Resources*, July 2002: http://www.nlchp.org/content/pubs/Inc_SSI_booklet.pdf
- O'Connell JJ, Quick PD, Zevin BD, PostPA (Ed.). (December 2004). *Documenting Disability: Simple Strategies for Medical Providers*; Special Considerations: 25-27. National Health Care for the Homeless Council. <http://www.nhchc.org/DocumentingDisability.pdf>
- Pecora PJ, Kessler RC, Williams J, O'Brien K, Downs AC, English D, White J, Hiripi E, White CR, Wiggins T, Holmes KE. (April 2005). Improving family foster care: Findings from the Northwest Foster Care Alumni Study. Seattle, WA: Casey Family Programs. <http://www.casey.org/Resources/Publications/NorthwestAlumniStudy.htm> [accessed 8/8/07]
- Perret YM. (June 2006). Co-occurring Disorders and SSI/SSDI: Policy Issues and Strategies. Presentation, HCH Policy Symposium. <http://www.nhchc.org/>
- Perret YM. SSI/SSDI for Homeless Adults with Co-occurring Disorders: A PATH National Teleconference sponsored by CSAT and SAMHSA, June 13, 2006. Transcript available at: http://www.pathprogram.samhsa.gov/pdf/transcripts/Transcript_SSI.SSDIforhomelessadults.pdf
- Perret YM. SSI Outreach Project, University of Maryland Medical System Division of Community Psychiatry, 9/2003: http://www.hrsa.gov/homeless/pdf/pa5_perret_handout_1.pdf [accessed 8/7/07]
- Post PA. (2001). *Casualties of Complexity: Why Eligible Homeless People Are Not Enrolled In Medicaid*. Nashville, TN: The National Health Care for the Homeless Council: 72-73. <http://www.nhchc.org/Publications/CasualtiesofComplexity.pdf>
- Public Law 104-121, Section 105: DAA provisions in the Contract with America Advancement Act of 1996: http://www.socialsecurity.gov/OP_Home/cfr20/404/404-0000.htm
- Ries RK, Comtois KA. Managing disability benefits as part of treatment for persons with severe mental illness and comorbid drug/alcohol disorders: A comparative study of payee and non-payee participants, *Am J Addict*; 6(4):330-8, Fall 1997.
- Rosen J and Perret YM. (2005). *Stepping Stones to Recovery: A Case Manager's Manual for Assisting Adults who are Homeless, with Social Security Disability and Supplemental Security Income Applications*. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. DHHS Pub. No. SMA 05-4051. <http://www.prainc.com/SOAR/tools/manual.asp> [accessed 8/8/07]
- Rosen J, Hoey R, and Steed T. Food Stamp and SSI benefits: Removing access barriers for homeless people, *Journal of Poverty Law and Policy*, March-April 2001: 679-696.

- Rosen MI, McMahon TJ, Lin H, Rosenheck RA. (Feb 2006). Effect of Social Security payments on substance abuse in a homeless mentally ill cohort; *Health Services Research* 41(1): 171-191. http://goliath.ecnext.com/coms2/gi_0199-5433701/Effect-of-social-security-payments.html#abstract
- Rosenheck RA, Dausey DJ, Frisman L, KasproW W. (Dec 2000). Outcomes after initial receipt of social security benefits among homeless veterans with mental illness, *Psychiatr Serv*;51(12):1549-54.
- Shaner A, Eckman T, Roberts LJ, Wilkins JN, Tucker DE, Tsuang JW, Mintz J. Disability income, cocaine use, and repeated hospitalization among schizophrenic cocaine abusers – A government-sponsored revolving door? *NEJM* 33(12): 777-783, September 21, 1995.
- Social Security Administration (SSA). *Understanding Supplemental Security Income: SSI Spotlight on Homelessness*. (2007 Edition). <http://www.ssa.gov/ssi/spotlights/spot-homeless.htm>; *Service to the Homeless*. <http://www.ssa.gov/homelessness/> [accessed 8/7/07]
- SSA. *Disability Evaluation under Social Security* (the “Blue Book”). (June 2006). SSA Pub. No. 64-039ICN 468600. <http://www.ssa.gov/disability/professionals/bluebook/> [accessed 8/7/07]
- SSA. *Supplemental Security Income (SSI) For Noncitizens*. (July 2005). SSA Publication No. 05-11051, July 2005, ICN 480360. <http://www.ssa.gov/pubs/11051.html> [accessed 8/7/07]
- SSA. *Consultative Examinations: A Guide for Health Professionals* (the “Green Book”). (Nov 1999). SSA Publication No. 64-025, ICN 954095. <http://www.ssa.gov/disability/professionals/greenbook/index.htm> [accessed 8/7/07]
- SSA. *Annual Statistical Report on the Social Security Disability Insurance Program* (2006). (released August 2007). http://www.ssa.gov/policy/docs/statcomps/di_asr/2006/ [accessed 9/7/07]
- SSA. *SSI Annual Statistical Report* (2005). (released May 2007). http://www.socialsecurity.gov/policy/docs/statcomps/ssi_asr/ [accessed 9/7/07]
- SSA Office of Disability Programs Disability Determinations and Appeals Fiscal Year 2006 (released January 2007). Chart provided by Sarah Anderson, Greater Boston Legal Services.
- SSA. *The Social Security Handbook*– a comprehensive guide to all of Social Security’s benefit programs: http://www.ssa.gov/OP_Home/handbook/ssa-hbk.htm [accessed 8/8/07]
- Social Security Administration (SSA). (2000). SSI: History of Provisions, Drug Addiction and Alcoholism (DA&A). *Social Security Bulletin*, Annual Statistical Supplement: 19-20. <http://www.ssa.gov/history/pdf/ssi.pdf>
- Social Security Administration (SSA). Program Operations Manual System (POMS): Section DI 90070.001: Drug Addiction & Alcoholism Provisions, P.L. 104-121, Overview. <https://s044a90.ssa.gov/apps10/poms.nsf/lnx/0490070001!opendocument>
- Section DI 90070.050: DAA Material Determinations. <https://s044a90.ssa.gov/apps10/poms.nsf/lnx/0490070050!opendocument>

Documenting Disability: Simple Strategies for Medical Providers

- Social Security Advisory Board. *Disability Decision Making: Data and Materials*, Part I: Data Relating to Disability Program Operations, January 2001:
<http://www.ssab.gov/NEW/Publications/Disability/chartbookB.pdf>
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2006). Results from the 2005 National Survey on Drug Use and Health: National Findings (Office of Applied Studies, NSDUH Series H-30, DHHS Publication No. SMA 06-4194). Rockville, MD.
<http://www.oas.samhsa.gov/NSDUH/2k5NSDUH/2k5results.htm> [accessed 8/7/07]
- U.S. Department of Health and Human Services (DHHS). About the Privacy Rule: Frequently Asked Questions. (May 24, 2007). <http://www.hhs.gov/hipaafaq/about/index.html> [accessed 8/7/07]
- DHHS. (1999). *Mental Health: A Report of the Surgeon General*, Chapter 2: The Fundamentals of Mental Health and Mental Illness: 46.
<http://www.surgeongeneral.gov/library/mentalhealth/pdfs/c2.pdf>
http://www.surgeongeneral.gov/library/mentalhealth/chapter2/sec2_1.html#epidemiology
- U.S. Government Accounting Office (GAO). (July 2004). *Social Security Administration: More Effort Needed to Assess Consistency of Disability Decisions*. GAO-04-656. Accessed 8/07/2007 at:
<http://www.gao.gov/new.items/d04656.pdf>
- World Health Organization (WHO). (2004). *Neuroscience of Psychoactive Substance Use and Dependence*.
http://www.who.int/substance_abuse/publications/en/Neuroscience_E.pdf
- Yates, Thomas. Preparing for and handling Social Security adult disability hearings, *Clearinghouse REVIEW Journal of Poverty Law and Policy*, May-June 2004, 12-26.
- Zerger S. (2002) *Substance Abuse Treatment: What Works for Homeless People? A Review of the Literature*. National Health Care for the Homeless Council.
<http://www.nhchc.org/Publications/SubstanceAbuseTreatmentLitReview.pdf>

WEBSITES:

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| Centers for Disease Control and Prevention
How to obtain vital records to verify eligibility for SSI or other benefits in all 50 States | http://www.cdc.gov/nchs/ |
| Centers for Medicare and Medicaid Services
First Step, Income Assistance | http://www.cms.hhs.gov/medicaid/homeless/ |
| Health and Disability Advocates | http://www.hdadvocates.org/index.htm |
| Health Resources and Services Administration
HIPAA website | http://www.hrsa.gov/website.htm |
| National Health Care for the Homeless Council
HCH Clinicians' Network | http://www.nhchc.org/ |
| National Law Center on Homelessness & Poverty | http://www.nlchp.org/ |
| National Organization of Social Security Claimants' Representatives (NOSSCR) | http://www.nosscr.org |

FEDERAL LAWS PROTECTING PATIENT CONFIDENTIALITY

Two Federal laws that protect patient confidentiality are relevant to the discussion of documenting disability:

- The **Privacy Act of 1974**, as amended, permits an individual or his/her authorized representative to examine records held by a Federal agency that pertain to him or her. This means that disability claimants may request to see the medical or other evidence used to evaluate their application for disability benefits under SSDI or SSI. SSA screens all such requests to determine if release of the evidence directly to the disability claimant might have an adverse effect on that individual. If so, the report will be released only to an authorized representative designated by the claimant.
- The **Privacy Regulations of the Health Insurance Portability and Accountability Act (HIPAA) of 1996** (Privacy Rule, 45 CFR parts 160 and 164) require health-related organizations (including Federally Qualified Health Centers) that handle certain transactions electronically (such as medical claims) to protect the privacy and security of their clients' personally identifiable health information. HIPAA protects any patient information (in oral, written, or electronic form), created or received by health care providers or plans, which identifies or could be used to identify the individual.

In general, the Privacy Rule requires medical providers, including health centers to:

- provide information to patients about their privacy rights, as specified in the Rule, and explain when the provider may and may not disclose protected information;
- adopt clear privacy procedures;
- educate and train employees regarding the privacy procedures;
- designate an individual to be responsible for ensuring that the privacy procedures are adopted and followed; and
- secure patient records containing individually identifiable health information so that they are not readily available to those who do not need them. (Bureau of Primary Health Care, 2001)

The HIPAA Privacy regulations are applicable when SSA seeks information for SSDI/SSI claims. The standard form used to authorize provision of a claimant's personal health information to SSA (Form SSA-827, "Authorization to Disclose Information to the Social Security Administration" <http://www.ssa.gov/online/ssa-827.pdf>) has been revised to meet HIPAA requirements.

STATUTORY BASIS OF DAA POLICY

Legislative history

Congress has played an active role in defining eligibility for Federal disability assistance of persons with impairments related to substance use. Three statutes passed by Congress and signed into law during the last 30 years are of particular interest to clinicians and advocates working with homeless SSI/SSDI claimants:

1972: Public Law 92-603 – defined Drug Addiction and Alcoholism as “potentially disabling” disorders, established the DAA program for SSI recipients, and required treatment and a representative payee for those with substance use disorders.

1994: Public Law 103-296 – mandated treatment referral and monitoring services for SSI beneficiaries with a DAA condition material to the finding of disability, to be administered by Referral and Monitoring Agencies (RMA) in every state. RMAs were responsible for placing these beneficiaries into treatment, arranging for payees, and monitoring their participation. Noncompliance with treatment requirements resulted in progressively longer payment suspensions, with termination of payments after 12 consecutive months of noncompliance.

1996: Public Law 104-121: The Contract with America Advancement Act (“Welfare Act”) of 1996 – prohibited entitlement to SSDI/SSI benefits for any individual whose drug addiction or alcoholism is “a contributing factor material to a determination of disability.” This law did not change the definition of ‘material’, but resulted in a finding of not disabled if DAA is ‘material’, and applied DAA representative payee requirements to “disabled SSI recipients who have a DA&A condition and are incapable of managing their benefits.” These recipients were referred to “the appropriate state agency administering the state plan for substance abuse treatment.”

Source: Social Security Bulletin, Annual Statistical Supplement, 2000. SSI: History of Provisions, 19–20.

Key provisions of Public Law 104-121:

- a. **Materiality** The 1996 law eliminates disability eligibility for cases in which DAA is a contributing factor “material” to the disability determination. 20 CFR 404.1535(b), 416.935(b). DAA is “material” only when the evidence establishes that the individual would not be disabled if s/he stopped using drugs or alcohol. POMS DI 90070.050D.3.
- b. **Representative Payees** Prior to enactment of this law, individuals whose drug addiction or alcoholism was material to the disability determination were required to receive their benefits through a payee. The 1996 Welfare Act eliminated eligibility for DAA beneficiaries and created a new class of beneficiaries – those with “DAA conditions.” A DAA condition exists when a beneficiary has a medically determined substance use disorder that is not material to the disability determination. There is no mandatory payee requirement for DAA condition beneficiaries.

Instead, SSA must determine, on a case-by-case basis, the capability of these beneficiaries. POMS GN 00502.010A.2., GN 00502.020A.4; HALLEX I-2-314A.

Source: Landry, Linda; Disability Law Center, Boston, MA. *DAA Issues Update (June 2006)*; *Disability Benefits Project SSI Coalition Newsletter*, XXV(3), May–July, 2006, 92–100

A firestorm of publicity around DAA benefits nationwide in the 1990s led to Congressional withdrawal of SSI/SSDI eligibility for persons whose DAA disorders were factors material to their disability. Two years after welfare reform laws brought an end to SSI for many poor people with substance use-related disabilities, research demonstrated continued high levels of alcohol and other drug use and significant material deprivation among those who lost Social Security benefits (See Baumohl et al. 2003). Since then, a number of research studies have demonstrated that homeless people with substance use disorders who receive SSI/SSDI disability payments are no more likely to purchase alcohol or drugs than are those who do not receive public support payments and have increased access to housing (Frisman and Rosenheck 2002, Rosen et al. 2006).

Case Law: Selected DAA Decisions (Landry 2006):

- **Determination of materiality with multiple impairments:**

Social Security Appeals Council decision, 12/3/98

Appeals Council states it is SSA's policy that materiality will not be found when there are multiple impairments and it is impossible to project what limitations would remain if the claimant stopped using drugs and/or alcohol, citing EM-96-94 (August 30, 1996).

- **Burden of proof:**

Brown v. Apfel, 192 F.3d 492 (5th Cir. 1999)

Court holds that the claimant bears the burden of proof that drug or alcohol addiction is not a contributing factor material to her disability. ...The court also cited DAA Q&A #29 from EM-96-94 (August 30, 1996) for the proposition that if the ALJ is unable to determine whether substance use disorders are a contributing factor material to the claimant's otherwise acknowledged disability, the claimant's burden has been met and an award of benefits must follow. In other words, the court asserted that "on the issue of the materiality of alcoholism, a tie goes to [the claimant]."

- **Correct DAA analysis:**

Brueggemann v. Barnhart, 348 F.3d 649 (8th Cir. 2003)

1. The ALJ must **make an initial determination of disability**, using the 5 step sequential analysis and taking into account all of claimant's limitations regardless of whether they are related to substance abuse. ...
2. The ALJ must **determine whether substance use is a concern** — i.e., whether there is material evidence of substance abuse.

3. If the claimant's limitations, including the effects of substance use, show disability, then the ALJ must next **consider which limitations would remain when the effects of the substance use disorders are absent.** This is the materiality determination. The court notes that "when the claimant is actively abusing alcohol or drugs, this determination will necessarily be hypothetical and therefore more difficult than the same task when the claimant has stopped." Despite this difficulty, the court continues, "the ALJ must develop a full and fair record and support his conclusion with substantial evidence on this point just as he would on any other." In other words, **active substance use does not preclude an award of benefits.**

- **Medical evidence standard:**

McGoffin v. Barnhart, 288 F.3d 1248 (10th Cir. 2002)

Court finds ALJ may reject treating physician's opinion outright only on the basis of contradictory medical evidence and not due to ALJ's own credibility judgments, speculation, or lay opinion. ... Court holds that non-treating physicians' assessments are not substantial evidence to refute evidence of treating physician when non-treating physician saw claimant only once a year prior to hearing, and expressed no opinion on claimant's cognitive abilities in a work environment. Court also affirms that **when mental restrictions due to DAA cannot be separated from other evidenced mental disorders, a finding of not material is appropriate.**

Alderete v. Barnhart, No. 03-2256, 101 Soc.Sec.Rep.Serv. 321, 2004 WL 1926221(10th Cir. August 31, 2004)

Court finds that treating physician's report should be given controlling weight only when "supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with other substantial evidence in the record."

ABOUT THE HCH CLINICIANS' NETWORK

Founded in 1994, the Health Care for the Homeless Clinicians' Network is a national membership association that unites care providers from many disciplines who are committed to improving the health and quality of life of homeless people. The Network is engaged in a broad range of activities including publications, training, research and peer support. The Network is operated by the National Health Care for the Homeless Council, and our efforts are supported by the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, and member dues. The Network is governed by a Steering Committee representing diverse community and professional interests. To become a member or order Network materials, call 615 226-2292 or write to network@nhhc.org.

ABOUT THE NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL

Founded in 1985, the National Health Care for the Homeless Council is a membership organization comprised of health care professionals and agencies that serve homeless people in communities across America. The National Council works to improve the delivery of care to homeless people, and to reduce the necessity for dedicated health care for the homeless programs by addressing the root causes of homelessness. Please visit our Web site at <http://www.nhhc.org>.